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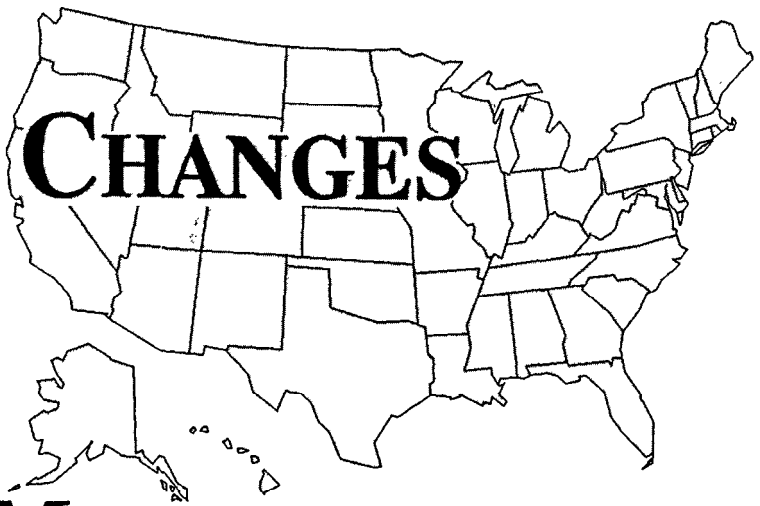
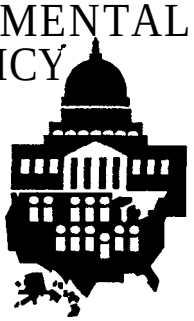


MAJOR CHANGES IN STATE MEDICAID AND INDIGENT CARE PROGRAMS 1989

The George Washington University
WASHINGTON DC

Compiled by

INTERGOVERNMENTAL HEALTH POLICY PROJECT



MAJOR CHANGES
in
STATE MEDICAID
and
INDIGENT CARE PROGRAMS

1989

by

Michele R. Solloway

with assistance from

Richard Jensen

INTERGOVERNMENTAL HEALTH POLICY PROJECT

The George Washington University

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The George Washington University
2011 'I' St., N.W. Suite 200
Washington, D.C. 20006

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MAJOR CHANGES IN STATE MEDICAID AND INDIGENT CARE PROGRAMS 1989

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FOREWORD AND ACKNOWLEDGEMENTS

This issue of Major Chanaes in State Medicaid and Indiaent Care Proarams is the 16th in a series published by the Intergovernmental Health Policy Project (IHPP), at the George Washington University, since January, 1981. Its timing comes at a critical juncture, both for IHPP and for the Medicaid program generally.

The Intergovernmental Health Policy Project is in its eleventh year of operation in 1989. Since its inception in 1978, the goal of the organization has been to enhance the quality and capability of health policymaking in the United States. IHPP is still the only university-based program in the country concentrating its research efforts exclusively on the health laws and programs of the 50 states. IHPP exists to facilitate the exchange of information about the experiences, successes and failures of state actions among decision makers in both federal and state government. We hope that this strengthens the capability of the states to address the increasing number of issues over which they have authority. As IHPP embarks on its ***second decade, the demand.for even more information on state activities should increase as the*** *Bush Administration increasingly relies on state governments for continued assumption of major responsibilities for financing, service delivery, administration and cost containment in the health arena.*

This is also a time of tremendous challenges for the Medicaid program, as it struggles to meet competing demands for long-term care services for the elderly and disabled with increasing responsibility for the care of low-income pregnant women and children. Medicaid has also become and is likely to remain a major payer for the care and treatment of the growing number of AIDS patients in the nation. And in the search for a solution to providing health coverage for the 37 million people in this country without insurance, Medicaid is frequently viewed as a potential base for expanded coverage.

This issue of Maior Chanaes offers a guide to states'approaches and initiatives in the financing and delivery of care to the poor adopted during the 1989 legislative period. As in previous reports, state profiles are arranged alphabetically and key words have been underlined in each entry to make it easier to locate policies pertaining to a particular subject. We have also retained the six categories of program activities -- Benefits & Coverage, Eligibility, Reimbursement, Administration & Management, Medicaid Related Strategies, and Indigent Care & Uninsured Programs. As Medicaid and indigent care programs continue to expand and diversity, they become increasingly complex and difficult to understand. In order to make this issue more "user friendly", we have eliminated the column format and added a cross-referenced subject index. The index allows the readers to find a specific policy according to any one of the six categories or a specific topic.

The report was written by Michele R. Solloway, Senior Research Associate; she coordinated the entire research effort and was responsible for analyzing all the laws and regulations. Richard Jensen assisted in the preparation of the state profiles. Linda Demkovich, Director of Communications for IHPP, contributed her editing skills to the narrative portions of the report. We are very appreciative of the contributions of Jean Zephir, graphic artist, and Helen Narvasa, computer operator, to the publication's design.

This report would not be possible without the assistance of the state Medicaid directors and their staffs, and of many other state and federal officials. They provide invaluable support by sharing information about new program initiatives, explaining the significance of new laws, and reviewing summaries of laws and rules to ensure their accuracy. We sincerely appreciate their cooperation in the preparation of this document. We also wish to express our appreciation to the Office oflntergovernmental Affairs, Health Care Financing Administration, U.S. Department of Health and Human Services for its support of IHPP's research activities on this and many other health policy issues.

In our continuing effort to make this publication as helpful to its users as possible, we welcome any feedback or suggestions for its improvement. It is our hope that this document will be a valuable resource to state and federal policymakers and will contribute to the overall improvement of state Medicaid and indigent care programs.

Richard E. Merritt, Director
Intergovernmental Health Policy Project

INTRODUCTION

The Medicaid program is the largest source of financing of medical care for the poor in this country, serving approximately 23 million Americans. It has been cited as one of the major factors in helping to improve the health status of the poor and has provided them with access to basic medical care for the 25 years since its inception. Even so, the program increasingly fails to cover more and more of the people it was created to serve -- those living in poverty without any other health insurance coverage. On average, only about 40 percent of all such individuals are covered by Medicaid and wide discrepancies in coverage among the states still remain.

While policymakers have become more attuned to the problems and the potential of the Medicaid program, new federal mandates and incentives have kept state governments extremely busy trying to keep up with increasing demands on an already complex and beleaguered program. During the 1989 legislative sessions, state legislatures passed more than 330 laws addressing some aspect of their Medicaid or indigent care programs and issued numerous regulations and program rule changes. More than 120 laws alone were enacted in response to the federal mandates included in the Omnibus Budget Reconciliation Act of 1987 (OBRA-87) and the Medicare Catastrophic Coverage Act of 1988.

New mandates and options, coupled with a pressing need to provide basic health care services to vulnerable populations, have constrained states as their Medicaid budgets continue to grow at an alarming rate. State Medicaid appropriations for FY 1989-90 increased an average of 12 percent over FY 1988-89, with some states showing an increase of more than 25 percent. Total program costs (both federal and state) also continue to escalate, jumping from $61.7 billion in 1989 to $71.7 billion in 1990, an increase of 16 percent; 1991 program costs are expected to reach approximately $80.2 billion. In part these numbers reflect expanded eligibility and benefits for pregnant women and children, populations whose health care needs are predictable and cost-effective, as well as increased costs for long-term care and nursing home services.

The overall theme for changes in state Medicaid programs this year was one of coordination and integration of services, both within Medicaid and between Medicaid and other state agencies. In addition, the 1989 legislative period saw a host of new or revived proposals to provide health coverage to the uninsured, reform Medicaid and change financing for long-term care services for the aged and disabled. Ideas ranged from those that would radically restructure state financing and program design to those that would continue the incremental expansion begun in the early 1980s. A number of states also examined ways to leverage private support by expanding employer-based health insurance to cover uninsured workers and their dependents; and a few states are considering some form of universal insurance that would incorporate Medicaid. Medicaid's growing costs, combined with the huge federal deficit and the perception of an impending recession, would appear to make any dramatic expansions in the first year of the new decade very unlikely.

This is also a time of great experimentation at the federal level. As proposals for reform surface in the 102nd Congress, legislators, health analysts, providers and public interest groups will need to assess the potential for success of those reforms. To do so, they will no doubt turn to the states to find out whether their ideas are feasible. This report offers those groups a guide to recent state approaches and initiatives in Medicaid reform as well as the financing and delivery of health care to the poor and to those in need of long-term care. The Intergovernmental Health Policy Project hopes that the information provided herein will prove helpful in the upcoming debates over how best to provide access to health care for all Americans.

HIGHLIGHTS AND TRENDS IN STATE MEDICAID PROGRAM CHANGES, 1989

OVERVIEW

Benefits and Service Coverage -- Many of the benefits added to Medicaid programs in 1989 were targeted towards pregnant women and children. At least 15 states added or expanded services for case management, maternity-related support services, EPSDT and psychiatric services. A number of states also broadened the range of non-institutionalized long-term care and related services to Medicaid recipients, including home health care (6 states), personal care and chore services (5 states), hospice (3 states) and respite care (3 states). In addition, while many states were already taking advantage of federal matching funds to provide additional services under Medicaid, several added optional services this year (see Table 1). Six states expanded the prescription drug benefit.

Eligibility -- Increasing program eligibility for pregnant women and children was a major focus in state legislatures, as the problems of infant mortality and low-birthweight babies gained national attention (see Table 2). Long-term care, and in particular eligibility for nursing home services, also took center stage as states moved to respond to federal mandates under the Medicare Catastrophic Coverage Act of 1988 (see Table 3 and Appendix 1). Federal mandates under the Family Support Act of 1988 also produced legislation in seven states.

Reimbursement -- Almost half of all state Medicaid programs effected changes in reimbursement, including changes in rates for nursing homes and home health care (10 states) and for hospitals that provide a disproportionate amount of uncompensated care to poor and uninsured patients (6 states). In part these changes reflect state efforts to respond to federal mandates under OBRA-87. Providers of maternal and child health services received rate increases in ten states; and three states examined new ways of financing prescription drugs.

Administration and Management -- Significant legislative and program activity occurred in response to nursing home reforms required under OBRA-87. Laws were enacted in the areas of nurse aide training (14 states), patient rights and disciplinary actions (21 states) and preadmission screening (13 states). In addition, 6 states added laws concerning other long-term care issues and 5 established or used existing management information systems to track program beneficiaries to improve planning efforts. In the area of cost-containment, a number of states attempted to realize greater program savings through more stringent penalties for fraud, increased recovery efforts and more liberal authority for states to gain access third-party liability.

Medicaid Related Strategies -- Clearly the most innovative legislation affecting state Medicaid programs in 1989 was Oregon's Medicaid Access plan which ensures access to health care for all residents under certain income levels and creates a commission to establish a priority ranking of health care services based upon comparative benefits of each service. Other state initiatives this year included Delaware's health insurance certification regulation and New York's eligibility demonstration project. Legislative action to experiment with financing or delivery of health care services also encompassed development of home and community-based waivers for AIDS patients and developmentally disabled individuals, using options under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) to expand access to health insurance, improving interagency coordination of maternal and child health services and developing a number of strategies for offering long-term care insurance.

TABLE 1

Optional Services In State Medicaid Programs, 1989

Basic Required Medicaid Services		Podiatrists' Services	Optometrists' Services	Chiropractors' Services	Other Practitioners' Services	Private Duty Nursing	Clinic Services	Dental Services	Physical Therapy	Occupational Therapy	Speech, Hearing and Language Disorder	Prescribed Drugs	Dentures	Prosthetic Devices	Eyeglasses	Diagnostic Services	Screening Services	Respiratory Care Services
	ALABAMA																	
	ALASKA																	
	ARIZONA																	
	ARKANSAS																	
	CALIFORNIA																	
	COLORADO																	
	CONNECTICUT																	
	DELAWARE																	
	D.C.																	
	FLORIDA																	
	GEORGIA																	
	HAWAII																	
	IDAHO																	
	ILLINOIS																	
	INDIANA																	
	IOWA																	
	KANSAS																	
	KENTUCKY																	
	LOUISIANA																	
	MAINE																	
	MARYLAND																	
	MASSACHUSETTS																	
	MICHIGAN																	
	MINNESOTA																	
	MISSISSIPPI																	
	MISSOURI																	
	MONTANA																	
	NEBRASKA																	
	NEVADA																	
	NEW HAMPSHIRE																	
	NEW JERSEY																	
	NEW MEXICO																	
	NEW YORK																	
	NORTH CAROLINA																	
	NORTH DAKOTA																	
	OHIO																	
	OKLAHOMA																	
	OREGON																	
	PENNSYLVANIA																	
	RHODE ISLAND																	
	SOUTH CAROLINA																	
	SOUTH DAKOTA																	
	TENNESSEE																	
	TEXAS																	
	UTAH																	
	VERMONT																	
	VIRGINIA																	
	WASHINGTON																	
	WEST VIRGINIA																	
	WISCONSIN																	
	WYOMING																	
15	CN	12	15	8	11	8	15	12	10	5	7	16	8	14	13	4	3	3
36	CN and MN	32	35	21	29	18	34	32	27	22	27	35	29	34	32	17	14	6
51	TOTAL	44	50	29	40	27	49	44	37	27	34	51	37	48	45	21	17	9

1. CN: Categorically Needy -- individuals receiving federally-supported financial assistance.
2. MN: Medically Needy -- individuals who are eligible for medical but not for financial assistance.

Source: Health Care Financing Administration, Division of Intergovernmental Affairs, 1990.

TABLE 1 CONTINUED:

Optional Services In State Medicaid Programs, 1989

Basic Required Medicaid Services: CN[1] / CN and MN[2]		Preventive Services	Rehabilitation Services	Services for Age 65 or Older in Mental Institutions: A. Inpatient Hospital Services	B. SNF Services	C. ICF Services	Intermediate Care Facility Services	ICF for Mentally Retarded	Inpatient Psychiatric Services for under Age 21	Christian Science Nurses	Christian Science Sanitoria	SNF for under Age 21	Emergency Hospital Services	Personal Care Services	Transportation Services	Case Management Services	Hospice Services	Total Additional Services
	ALABAMA																	14
	ALASKA																	18
	ARIZONA																	20
	ARKANSAS																	25
	CALIFORNIA																	27
	COLORADO																	16
	CONNECTICUT																	26
	DELAWARE																	17
	D.C.																	26
	FLORIDA																	19
	GEORGIA																	15
	HAWAII																	23
	IDAHO																	15
	ILLINOIS																	28
	INDIANA																	28
	IOWA																	22
	KANSAS																	25
	KENTUCKY																	25
	LOUISIANA																	16
	MAINE																	27
	MARYLAND																	19
	MASSACHUSETTS																	32
	MICHIGAN																	30
	MINNESOTA																	30
	MISSISSIPPI																	16
	MISSOURI																	18
	MONTANA																	28
	NEBRASKA																	24
	NEVADA																	25
	NEW HAMPSHIRE																	28
	NEW JERSEY																	28
	NEW MEXICO																	16
	NEW YORK																	28
	NORTH CAROLINA																	21
	NORTH DAKOTA																	25
	OHIO																	26
	OKLAHOMA																	18
	OREGON																	26
	PENNSYLVANIA																	20
	RHODE ISLAND																	18
	SOUTH CAROLINA																	19
	SOUTH DAKOTA																	16
	TENNESSEE																	20
	TEXAS																	18
	UTAH																	26
	VERMONT																	24
	VIRGINIA																	22
	WASHINGTON																	28
	WEST VIRGINIA																	22
	WISCONSIN																	30
	WYOMING																	11
15	CN	3	12	17	9	11	23	23	12	1	5	21	14	7	15	6	4	
36	CN and MN	16	28	24	16	19	28	27	26	4	12	29	27	19	35	25	20	
51	TOTAL	19	40	41	25	30	51	50	38	5	17	50	41	26	50	31	24	

1. CN: Categorically Needy -- individuals receiving federally-supported financial assistance.
2. MN: Medically Needy -- individuals who are eligible for medical but not for financial assistance.

Source: Health Care Financing Administration, Division of Intergovernmental Affairs, 1990.

TABLE 2

STATE ELIGIBILITY THRESHOLDS FOR PREGNANT WOMEN AND CHILDREN,' 1989

	Pregnant Women and Infants: Percent of Poverty [2]	Pregnant Women: Presumptive Eligibility	Pregnant Women: Continuous Eligibility	Children: Percent of Poverty	Children: Age Limit
ALABAMA	100				
ALASKA	100			100	2
ARIZONA	130			100	6
ARKANSAS	100			100 [3]	6
CALIFORNIA	185 [4]			100	5
COLORADO	75				
CONNECTICUT	185				
DELAWARE	100			100	3
D.C.	100			100	2
FLORIDA	150			100	6
GEORGIA	100			100	3
HAWAII	185			100	4
IDAHO	75				
ILLINOIS	100				
INDIANA	100			100	3
IOWA	185			100	6
KANSAS	150			100	5
KENTUCKY	125			100	2
LOUISIANA	100			100	6
MAINE	185			1005	5
MARYLAND	185			100	2 [6]
MASSACHUSETTS	185			100	5
MICHIGAN	185			100	3
MINNESOTA	185			100	8 [7]
MISSISSIPPI	185			100	5
MISSOURI	100			100	3
MONTANA	100			40 [8]	6 [9]
NEBRASKA	100			100	5
NEVADA	75			75	6
NEW HAMPSHIRE	100				
NEW JERSEY	100 [10]			100	2
NEW MEXICO	100			100	3
NEW YORK	185				
NORTH CAROLINA	150			100	7
NORTHDAKOTA	75				
OHIO	100				
OKLAHOMA	100			100	2
OREGON	85			85	3
PENNSYLVANIA	100			100	6
RHODE ISLAND	185			100	6
SOUTH CAROLINA	185			100	6
SOUTH DAKOTA	100				
TENNESSEE	100			100	6
TEXAS	130			100	4
UTAH	100				
VERMONT	185 [11]			225 [12]	6
VIRGINIA	100				
WASHINGTON	185	[13]		100	8
WEST VIRGINIA	150			100	6
WISCONSIN	120 [14]				
WYOMING	100				

NOTES

1. **Excludes** special programs for children.

2. see Appendix 2.

3. Uninsured children's program (HB 1506, 1969) **will** cover children with **family** incomes up to 165% of poverty who are not covered by Medicaid or other public assistance programs.

4. **State-only** funds from the "Cigarette and Tobacco Products Surtax Fund (AB **75,** 1969) covers pregnant women with incomes between 185% and **200% of poverty.**

5. **"MaineCare"** program (HB 954. 1969) covers children under 16 **with** famity incomes **below** 125% of poverty with state-only funds.

6. The 'Children's **Health Plan"** (HB **1759, 1989)** provides ambulatory **health** care to children under **18** with **family** incomes below 165% of **poverty** with state-only funds. includes a small enrollment fee.

7. The state is **authorized** under SB 794 (1969) to increase coverage **up** to age 7 **(inclusive)** depending on the **availability** of state and federal financing.

6. Based on income **eligibility** for the Medically Needy program which is **$408/month** for a family of 3 in **1989.** Income threshold will **increase** to **$410/month** as **of** January 1.1990.

9. Covers children in two-parent families whose incomes allow them to **qualify** for medical assistance under either the AFDC or the Medically Needy programs.

10. New 'MOMS" (Maternity Outreach Managed Services) Program extends the same prenatal services **available** to those enrolled in the **HealthStart** Program to all pregnant women. Services are free to clients whose **family** incomes **are** below 159%. and a sliding-scale fee is imposed **for those** whose incomes fall between 150% and 250% of poverty. Services are available to pregnant women **with** incomes over 250% of poverty at established rates. The program is scheduled to go into **effect** in the spring of 1990.

11. State-only funds cover pregnant women and **infants** with family incomes between 165% and 200% of poverty.

12. State-oniy funds.

13. The 'Maternity Care Access Act of **1989"** (HB 2244.1969) requires the state to study the **feasibility** and **desirability of** implementing **presumptive** eligibility **for** pregnant women.

14. **State-only** funds. **Wisconsin** will use Medicaid funds to increase eligibility to 135% in July 1990.

TABLE 3

STATE IMPLEMENTATION OF THE MEDICARE CATASTROPHIC COVERAGE ACT OF 1988

Laws and Regulations, 1989

	PREGNANT WOMEN AND CHILDREN[1]	MEDICAID BUY-IN	SPOUSAL IMPOVERISHMENT	TRANSFER OF ASSETS
ALABAMA	2	2	2	2
ALASKA	●	2	2	●
ARIZONA	2	/	/	
ARKANSAS				
CALIFORNIA 3	2			
COLORADO	/	/	/	/
CONNECTICUT	2			
DELAWARE	2		● 4	● 4
D.C.	2	2		2
FLORIDA	/	2		
GEORGIA	2	/		
HAWAII	/		/	● /
IDAHO				/
ILLINOIS	2			
INDIANA	/	/		
IOWA	/	/		/
KANSAS			/	/
KENTUCKY				
LOUISIANA				
MAINE				
MARYLAND				
MASSACHUSETTS	2			
MICHIGAN	2			
MINNESOTA	2			
MISSISSIPPI	2			
MISSOURI		/	/	
MONTANA	/	/		
NEBRASKA	2		/	● /
NEVADA	/	/		
NEW HAMPSHIRE			5	5
NEW JERSEY	2	2	●	4
NEW MEXICO			/	
NEW YORK	/ ●	/ ●	/	/
NORTH CAROLINA	/			
NORTH DAKOTA				
OHIO				
OKLAHOMA				
OREGON				
PENNSYLVANIA	2			
RHODE ISLAND	/	/	/	
SOUTH CAROLINA	/	/		
SOUTH DAKOTA			/ ●	/ ●
TENNESSEE	/			/
TEXAS	/			
UTAH	2			
VERMONT	/			
VIRGINIA				
WASHINGTON	/		/	/
WEST VIRGINIA	2			
WISCONSIN	/			/
WYOMING	2			

KEY:

/ LAW — REGULATION

● BILL RENDING — ● REGULATION PENDING

FOOTNOTES:

1. Only seven states -- CO, ID, IN. MT, NV, NH, and ND -- were below the federally mandated level of coverage (75% of poverty). Nonetheless, the increase in federal income eligibility thresholds prompted a number of states to increase their standards this year. Table 3 indicates only those states that increased eligibility for pregnant women and children in 1989. For actual income thresholds, see Table 2.

2. Law or regulation not required.

3. California will not implement MCCA until 1990

4. Requires enabling legislation to implement.

5. Interim regulation.

Source: Intergovernmental Health Policy Project, 1989.

I. BENEFITS AND SERVICE COVERAGE

A. Pregnant Women and Infants:

In keeping with national attention on the problems of infant mortality and low birthweight babies, pregnant women and infants were major targets for program expansions this year. Although most efforts were aimed at increasing access through eligibility (see below), a number of states expanded the scope of services provided to this population. Delaware extended additional services to eligible pregnant women who are at risk of having premature or low birthweight babies. These services, which require prior authorization from the Medicaid Administrator, include nursing, nutrition and social services. Iowa and Indiana expanded case management programs for pregnant women and infants; Iowa's program, which was implemented on a demonstration basis, was extended to all parts of the state. Montana added ambulatory care for pregnant women during the period of presumptive eligibility, while Vermont expanded coverage for pregnant women and infants by eliminating the resource test. Texas reauthorized its medically needy program for pregnant women, children and caretakers with high medical expenses. Finally, Arkansas, Kentucky, Mississippi and Tennessee extended coverage for inpatient hospital care for infants to the extent possible under federal law.

B. Children's Services

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services were expanded in a number of states, including Iowa, Massachusetts, Montana, Oklahoma and Virginia. As with services to pregnant women, Iowa's demonstration program was extended on a statewide basis. Oklahoma revised its EPSDT schedule to conform to the recommendations by the state chapter of the American Academy of Pediatrics. Massachusetts also revised its EPSDT medical protocol, changing the 20-month age level to 18 months to coincide with the immunization schedule. The state also moved up the age for testing children's cholesterol levels and screening for sickle cell anemia and added a tests for chlamydia and a fluoride assessment.

Six other states approved laws affecting children's access to state medical assistance passed in six states. Montana added inpatient psychiatric services for children under 21 to the state Medicaid program, while Virginia instituted coverage of self-monitoring test strips for diabetic children under 21 years of age. Four states increased access via child support services. Indiana expanded coverage to Medicaid eligible children under 18 who are wards of county public welfare department. Oregon enacted a law that allows individuals who have been assigned rights for child support to elect to receive medical support through Medicaid. The state also expanded "Duty of Support" to include a duty to provide medical and dental insurance coverage for dependents. Two other states -- Mississippi and Rhode Island -- authorized the appropriate state agency to enter into interstate agreements with agencies of other states to pay for medical expenses associated with adoption, particularly for children with special needs or hard-to-place children.

C. Long-Term Care:

The state of Washington enacted a law this year to establish a coordinated and balanced range of community-based health, social and supportive long-term care services to all chronically, functionally disabled individuals. The law directs the state to ensure the following: (1) a uniform and comprehensive assessment system to determine a client's level of functional disability; (2) service alternatives that minimize institutionalization and allow clients to receive care in their homes or in community-based facilities; (3) a state-wide case management system to effectively coordinate a client's plan of care; and (4) the development of a coordinated system of long-term care education that reflects both in-home care and institutional care needs of this population. In addition, the state is directed to develop an expanded network of volunteer providers, specifically for chore services, and to coordinate services among participating agencies to minimize administrative costs, avoid duplication and maximize financial resources. To achieve these goals, the state will expand community-based long-term care services, such as chore services, respite care, personal care and hospice, case management and adult family homes, to take advantage of these optional service categories allowed under federal law. Expansion of long-term care services will require amendments to the state's Medicaid plan.

In other legislative action around the country, **Kentucky** established a Brain Injury Program under its Skilled Nursing Facility (SNF) services to provide quality standards for intensive rehabilitation services. In addition, **Kentucky** removed the limit on the number of benefit days under the state's hospice program. **Missouri** and **Montana** added hospice as an optional benefit under their Medicaid programs. Montana's program, however, is scheduled to terminate by June of 1991 unless it is extended by the legislature. Texas also took action in this area by authorizing hospitals to provide respite care. In other legislative areas, Massachusetts increased the personal needs allowance for nursing home residents; and **Oregon** authorized the state's Senior and Disabled Services Division to contract with private entities to provide or contract for case management services under long-term care insurance for elderly and disabled populations.

D. **Personal Care and Chore Services:**

Indiana, New York, South Carolina and **Washington** all added or expanded personal care services under Medicaid. Indiana added emergency response services as a personal care service, while New York also included medical social services, nutritional counseling, respiratory therapy, and adaptation to the home and community-based services. The state of Washington now requires that plans of care for personal care services be approved by a physician and reviewed by a nurse every 90 days. The legislature also directed the state to provide chore services through volunteer providers rather than through paid providers for clients who are at risk of being placed in a residential care facility, are over 60 and are eligible for 5 hours of chores services per month or less. In addition, individuals who are eligible for adult protective services are also eligible to receive emergency chore services without regard to income for up to 90 days if the services are essential to the protective services plan. If the state needs to make reductions in the program, it may make cuts by classes of eligibles rather than by cutting services. Individuals previously receiving chore services (both household and attendant services) under the state-only program are grandfathered into this program.

E. Prescription Drugs

A number of changes were made in the coverage of prescription drugs this year. Alaska made permanent the inclusion of the prescription drug benefit under Medicaid (the prescription drug benefit was included on a temporary basis in 1988). This benefit is now available in all states and the District of Columbia. Three states -- Arkansas, Mississippi and South Carolina -- increased the level of the drug benefit. Arkansas increased coverage from 4 to 6 prescriptions per month per recipient; Mississippi now allows 5 prescriptions per month for non-institutionalized Medicaid recipients; and South Carolina added coverage for an additional prescription per month, raising the maximum number of prescriptions to 4 per month per recipient. Also, California now covers prescription drugs for Qualified Medicare Beneficiaries (QMBs -- see Appendix 1), provided that Medicare recipients are offered the same drug coverage as categorically needy recipients.

Two states took action on prescription drugs for AIDS patients. California established a new drug program for persons with HIV infection that will pay for AZT, Aerosolized Pentamidine and Gangciclovir for persons with annual incomes of up to $30,000, with some subsidies for those above that level. Oklahoma expanded the medical necessity criteria for coverage of AZT under Medicaid.

At the same time that states are expanding the prescription drug benefit, they are also looking for ways to control costs. Three states -- Connecticut, Indiana and Maryland -- added laws that permit or require substitution of generic drug products unless the prescribing physician specifies "Brand Medically Necessary" on the prescription. Virginia discontinued coverage of transdermal drug delivery system.

II. ELIGIBILITY

A. Pregnant Women and Infants:

As mentioned above, much legislative activity in 1989 revolved around expanding access to maternity-related care. Fifteen states increased eligibility thresholds for pregnant women and infants: Five of them -- Colorado, Idaho, Nevada, New Hampshire and North Dakota -- phased in higher income eligibility levels to conform with federal law requiring coverage of all pregnant women and infants at or below 75 percent of poverty. Both Indiana and Montana, which were also below the federally mandated level, increased their income thresholds to 100 percent of poverty. Income eligibility for Florida and Kansas jumped from 100 percent to 150 percent of the poverty level. Hawaii, Iowa, Maryland, New **York, South Carolina** and **Washington** all raised their income eligibility standards to 185 percent of the federal poverty standard -- the maximum level allowed under federal law.

To expedite Medicaid coverage for prenatal care visits, 6 states, including Colorado, **Iowa, Montana, New Mexico, New York** and **Texas,** implemented presumptive eligibility. Presumptive eligibility allows women to begin receiving prenatal care, generally for up to 45 days, while their eligibility status is being determined. This brings to **24** the number of states that have incorporated presumptive eligibility into their Medicaid programs. Three additional states -- Arkansas, New York, and Virginia -- added continuous eligibility, allowing uninterrupted coverage throughout pregnancy

and generally for 60 days post partum. As a result of these new laws, 41 states now offer continuous eligibility to pregnant women.

Two other states relaxed eligibility criteria for prenatal care services: Kentucky eliminated the resource test for program eligibility; and Alabama allowed pregnant women who have lost Medicaid benefits because of fraud, abuse or misuse to be reinstated on a restricted status for pregnancy-related services only. Under this law, each case must be reconsidered by a utilization review committee within 60 days after the birth of the child.

B. Children's Services:

Children, another vulnerable population, were targeted for 1989 program expansions in 10 states. Arkansas, Hawaii, Indiana, Iowa, Maryland, Minnesota, Mississippi, Montana, North Carolina and Washington increased access to care by raising either age or income eligibility thresholds. In addition, Connecticut and Montana created opportunities to augment program eligibility for children. Connecticut now allows the regional or local Board of Education to request permission from a parent or legal guardian to apply for Medicaid on the behalf of a child who has been identified by the Board as needing a special education program and determined to be eligible for Medicaid. Montana revised eligibility standards to include children under **21** in foster care who are or were wards of the state and have been adopted as hard-to-place children as well as individuals under 19 years of age who qualify for AFDC.

C. Long-Term Care:

Legislation concerning Medicaid beneficiaries who are at risk of institutionalization was passed in at least 2 states in 1989. Colorado created a program to provide less costly community-based or home health services to disabled children who are 18 years of age or under and who (1) have medical needs that would require or place them at risk of being institutionalized; (2) are currently institutionalized under Medicaid; (3) have incomes at or below 300% of the income benefit level for SSI; and (4) are not eligible for other long-term care waiver programs. And Washington made chore services available on a sliding-fee scale to individuals who are not categorically eligible for such services under Medicaid and whose income does not exceed 30% of the state median income. Eligibility assessment criteria will include the client's level of functional disability and risk of institutionalization.

D. Spousal Impoverishment:

Under the Medicare Catastrophic Coverage Act of 1988, a spouse of a nursing home resident (called a "community spouse") is allowed to retain half of the couple's assets, with a minimum level of $12,000 not to exceed $60,000 (the states may set a lower limit anywhere between these two figures) and a maximum monthly allowance of $1,500 unless otherwise specified by the court. Eighteen states enacted laws and 31 states developed regulations to implement the mandated spousal impoverishment rules. Delaware has proposed legislation, while New Jersey and South Dakota have regulations pending. Neither laws nor regulations are required in Alabama or Alaska for implementation of this provision. While most states have adopted the federal standards, a few states -- California, Kentucky, New **York, Washington** and **Wisconsin -**

- have set the minimum community spouse resource limit at $60,000, the maximum allowed under federal **law. New Mexico** chose a limit of $30,000 and **North Dakota** set the minimum resource limit at $25,000, more than double the federal standard.

E. Transfer of Assets:

A similar situation applies to state implementation of federal rules governing the treatment of an institutionalized spouse's transferred assets in making an eligibility determination for nursing home services under Medicaid. Federal law requires states to make institutionalized residents ineligible for these services if they have disposed of their resources at less than fair market value within a period of 30 months before applying for Medicaid. Previously, the period of ineligibility was 24 months and was implemented as a state option. In 1989, 15 states enacted legislation and 31 states promulgated regulations to bring state statutes into compliance with federal requirements concerning the transfer-of-assets provision, while 5 have legislation or regulations pending. New **Hampshire** reduced the period of ineligibility from 36 to 30 months In addition, Idaho also applied the transfer-of-assets concept to individuals applying for AFDC.

F. Transitional Medicaid Coverage:

Seven states--California, Florida, Illinois, Louisiana, Massachusetts, Missouri and Montana -- enacted legislation to bring their statutes into compliance with requirements under the Family Support Act of 1988' which extends coverage to AFDC families who lose Medicaid benefits as a result of income gained from employment. The new California law also continues Medi-Cal (the state's Medicaid program) eligibility for conditions excluded from coverage by private insurers to disabled persons who are otherwise eligible for Medi-Cal, except for income due to employment. The law applies only to individuals whose income does not exceed 200% of the maintenance level established by the state and is contingent on availability of federal matching funds. Under Florida's law, the Department of Health and Rehabilitation Services may use funds to pay for a family's premiums, deductibles, coinsurance and similar costs for health insurance or other coverage offered by an employer of one of the parents. It also extends medical assistance to two-parent AFDC families with children under 18 where at least one of the parents is unemployed. Louisiana's law requires cost-sharing by recipients and also allows the state to request a federal waiver to use matching federal funds for these additional services.

H. Veterans' Health:

Three states enacted legislation pertaining to the health of U.S. veterans. Laws enacted in Maine and New York exclude income received from liability litigation concerning Agent Orange in determining eligibility for public assistance programs, including Medicaid. Regulations developed in New Mexico exclude the portion of a Veteran's Administration Improved Pension (VAIP) benefit intended for unreimbursed medical expenses for purposes of eligibility determination. The entire amount of the VAIP benefit will, however, be counted for purposes of computation of the medical care credit.

'See Maior Changes. 1988, Appendix 1, p. 95 for a description of this law.

III. REIMBURSEMENT

A. Maternal and Child Health:

Pregnant Women and Infants: In an effort to encourage providers to participate in the Medicaid program, a number of states increased reimbursement levels for obstetrical and maternity related services. They include New Mexico, North Carolina, Vermont and Washington. Nurse-midwives in New Mexico will now be reimbursed at 77 percent of the Medicaid rate. They may also bill for delivery supplies, venipuncture, hemoglobin, hematocrits and mileage for home visits in excess of 75 miles roundtrip. In related action, Florida enacted legislation that requires the state to establish rates for obstetrical and neonatal care for high-risk pregnant Medicaid recipients and neonatal babies with life threatening conditions. The rates will apply to physicians who provide services in Regional Perinatal Intensive Care Centers. The legislation also eliminates the inpatient day limit for children under one year of age whose family income is below 150 percent of the federal poverty level. Finally, California eliminated the differential in payment between Caesarean section and non-Caesarian section services.

Children's Services: Several states increased fees for children's services. Through regulation, Massachusetts increased home assessment rates for children with special needs; Montana increased fees for EPSDT services; and Oklahoma revised its EPSDT fee schedule to include payment for eyeglasses. In addition, Iowa is changing its reimbursement for psychiatric medical institutions for children, and California has made permanent the pediatric diagnosis related group (DRG) system for reimbursing children's hospitals.

B. Nursing Homes:

One of the major nursing home reform provisions under OBRA-87 calls for eliminating the difference between a SNF and an ICF, calling each a "nursing facility," or NF. This law requires states to adjust payment rates for these facilities and to allow for additional costs associated with these reforms. The new reimbursement rates must take into account increased requirements for staffing and nurse aide training programs as well as for additional services related to residents' quality of care and quality-of-life.

In Delaware, providers of ICF and SNF care will now be reimbursed based on a patient index classification system composed of 5 prospectively-determined rate components. The assignment to a classification for primary care reimbursement is based on the patient's characteristics and special service needs. Patients may also qualify for supplementary reimbursement for rehabilitative and/or psycho-social programs. Providers' costs are reported annually to the Medicaid agency. These cost reports are then used to establish per diem rates for each facility and the rate ceiling for the secondary, support and administrative cost centers in each provider peer group.

In a related action, Arkansas increased its nursing home reimbursement rates 15% over previous per diem rates and also requested a study of reimbursement methodologies and better information to the public on the quality of care in any given nursing home. Maine also revised its nursing home reimbursement rules to clarify that flat rates will not be used and adjustments should be made to take into account changes in

staff wages. A new law in **Illinois** clarifies that payment to nursing homes for support services (i.e., laundry, dietary, housekeeping, utilities and administration) will be calculated by assessing the individual facility's per diem cost relative to the average per diem cost of all nursing homes within that Health Service Area. A nurse wage adjustment factor will be included in computing nursing home rates, as mandated under federal law.

A new **Connecticut** law limits the growth of Medicaid payments for nursing homes, certain chronic disease hospitals and residential facilities for the mentally retarded and increases the payment differential between the Medicaid and private-paying nursing home rates for 2 years. It also reduces cost-efficiency adjustments, eliminates payments for personal laundry and certain interest expenses, reduces the impact of inflation on the rates and imposes an overall percentage rate reduction.

Idaho will pay facilities a special add-on rate under Medicaid if they provide services to patients with long-term care needs beyond the normal scope of the facilities, including but not limited to ventilator assisted patients and certain pediatric and comatose patients, as well as patients who require nasogastric or intravenous feeding devices. Payment for such services is in addition to other payments under Medicaid. Costs attributed to providing extra long-term care services will not be included in the computation of Medicaid cost-based rates.

Two states -- **Massachusetts** and Iowa -- enacted laws concerning nursing home services for AIDS patients. The new **Massachusetts** law allows payment for specialized nursing units (SNUs) to care for patients with AIDS or ARC. Reimbursement for SNUs will be on a prospective, case-mix basis. Regulations stipulate that providers must reserve at least 60% of the total SNU beds for Medicaid recipients of which a minimum of 15% must be single occupancy rooms reserved exclusively for patients whose medical and social needs dictate that the rooms should not be shared. The state also adjusted reimbursement rates for hospice room and board in SNFs and ICFs to reflect costs in the county in which the nursing home is located. Iowa increased reimbursement for long-term care facilities to meet the care needs of persons with infectious diseases.

C. Home Health, Personal Care and Hospice:

In order to facilitate the provision of home health services by relatives, Indiana enacted a law that allows Medicaid beneficiaries' relatives who are trained to provide homemaker and personal care services to be reimbursed if providing those services to the beneficiaries creates a financial hardship for the relative. Colorado set the maximum reimbursement for personal care services provided by a family member, except a spouse, at $5000 per family per year or 50% of the maximum amount of authorized expenditures under Medicaid. As mandated by federal law, personal care services provided by a spouse are not reimbursable under Medicaid.

D. Disproportionate Share Hospitals:

The recent surge of drug abuse and the devastating outcomes of drug-related health problems, particularly for women and infants, has had a tremendous financial impact on disproportionate share hospitals -- the primary providers of health care services to the poor. Under federal law, states must conform to certain requirements in order to receive matching funds for the disproportionate share adjustments. This year, three states -- Illinois, Minnesota and Washington -- joined the ranks of those that

have brought their state statutes into conformance with these federal requirements. The Illinois law also made provisions for rate adjustments for hospitals in health manpower shortage areas with high Medicaid patient loads and for children's hospitals. In addition, California established a "Disproportionate Share and Emergency Services Fund" to provide additional reimbursement to hospitals participating in the Medi-Cal program that serve a disproportionate share of low-income patients; and Kentucky increased the reimbursement rate for disproportionate share hospitals for services to infants under one year of age.

Florida has established criteria and a methodology to determine a hospital's disproportionate share rate. In addition, hospitals that participate in the Regional Perinatal Intensive Care Center (RPICC) program will be eligible to receive payments as a disproportionate share provider; however, the reimbursement rates are designated by a different formula. These particular providers are also subject to additional requirements regarding staffing ratios, quality assurance, evaluation and data collection efforts and provision of support services.

E. Prescription Drugs

A unique law enacted in California's 1989 session allows reimbursement of all medically necessary inpatient and outpatient services associated with the administration or treatment of investigational new drugs (IND) under the state's Medicaid program. Georgia established the "Medicaid Prescription Drug Bidding & Rebate Program," which will request sealed bids from manufacturers for specified drugs. Manufacturers receiving contracts will be given rebates for the amount of the bid price for drugs (for which they awarded a contract) when those drugs are supplied to Medicaid recipients. If no acceptable bids are received, the state may select a single supplier for a drug. In a similar move, Louisiana established a "Medicaid Drug Program Committee" and required an expansion of the state's Medicaid formulary.

IV. ADMINISTRATION & MANAGEMENT

A. Nursing Home Reforms under OBRA-87:

Passage of the Omnibus Budget Reconciliation Act of 1987 brought about some of the most sweeping changes in more than a decade in the conditions of participation for nursing homes providing care to Medicare and Medicaid patients. Although the implementation dates for various reforms have been changed or delayed several times, the new budget law (OBRA-89) requires implementation of the nurse aide training and competency evaluation requirement as well as for the preadmission screening and annual resident review process by October 1, 1990 (see Appendix 1). Because of the delays and changes in the implementation dates, and in the absence of federal guidelines, state oversight activities in 1989 focused on complying with the intent of the law rather than on meeting the statutory deadlines. Three nursing home reforms discussed here cover: (1) nurse aide training; (2) patient rights and disciplinary actions; and (3) preadmission screening.

Nurse Aide Training: Under OBRA-87, all nurse aides employed by nursing home participating in Medicare and/or Medicaid must be tested through a state-approved program and deemed competent to perform their designated duties. In addition, states must develop and maintain registries to monitor nurse aide training, certification and employment. Fourteen states enacted laws to bring state statutes into compliance with federal requirements.

Patient Rights and Disciplinary Actions/Civil Money Penalties: A number of states have passed laws or developed rules and regulations needed to implement federal nursing home reform provisions for imposing disciplinary sanctions on facilities that violate federal nursing home standards. In general, this involves the establishment of a nursing home penalty cash fund to be used for the following purposes: (1) relocating residents to other nursing facilities; (2) enforcing the rights of the patients in the event of relocation; (3) maintaining the operation of a nursing facility pending correction of violations; (4) closing a nursing facility; and (5) reimbursing residents for personal funds lost. The funds may not be used to pay states' administrative costs. Provisions identify the range of allowable civil money penalties and procedures for determining the amount of such a penalty as well as the procedures for appeals. Seven states enacted laws for both disciplinary actions and patient rights; 7 added only disciplinary sanctions; and another 7 passed only patient rights laws.

Preadmission Screening: OBRA-87 mandated revisions in the way mental health care services are to be provided in nursing homes. A major part of this change included requirements for Preadmission Screening and Annual Resident Review (PASARR). This assessment was designed to identify those persons with mental illness or mental retardation who may have been misdiagnosed or misplaced in a nursing home facility. Such individuals may be going without active treatment for their mental disability, and the federal law mandates that they receive the mental health services they require. Individuals who have resided in an nursing facility for more than 30 continuous months prior to January 1, 1989 (the effective date for PASARR under OBRA-87) and who need active treatment for their mental disability rather than nursing home care must be given the option of remaining in the nursing facility or transferring. Individuals who elect to remain in the facility must be provided active treatment. The law requires that residents who have been institutionalized less than 30 continuous months and are diagnosed as mentally ill or mentally retarded must be placed in an alternative setting. It further requires the state to finance necessary services with state-only funds. Those individuals who do not require such treatment or do not need nursing home care must be discharged.

Although 35 states already have a preadmission screening program in place, most did not screen for mental illness or mental retardation. Exceptions to this include New **York, California, Indiana, Kentucky** and **Oklahoma.** Compliance with the preadmission screening regulations has been delayed under OBRA-89 until October 1, 1990. States that identified nursing home patients who require active treatment may submit to HCFA Alternative Disposition Plans (ADPs) if they feel they would be unable to find alternative placements for needy individuals by April 1, 1990. Most states submitting ADPs (all but two did) requested an extension until 1994. The estimated number of individuals who are likely to require new placement vary by state and may not be known until later in 1990. Thirteen states added preadmission screening to their state statutes. **Oregon** also added assessment provisions for non-Medicaid clients.

B. Long-Term Care and Related Services:

In addition to laws and regulations affecting nursing homes, a variety of initiatives affecting other long-term care and community-based services, such as hospice and respite care, were enacted this year. Louisiana passed legislation that authorizes the Department of Health and Hospitals to establish a 2-year moratorium on approval of Medicaid long-term care beds. Indiana established a program to train relatives of eligible individuals to provide homemaker and personal care services to those eligibles, while Illinois created the Long-Term Care Monitor/Receiver Fund to finance monitors and receivers of nursing homes. The fund will be supported by a $200 application fee required by nursing homes seeking a license. Wyoming implemented a pilot project for on-site level of care determination for long-term care admissions by public health nurses in 5 counties to determine statewide applicability. The project is scheduled to become effective on a statewide basis later this year.

Washington enacted two laws affecting the administration of the state's long-term care program. The first created a long-term care commission to design, plan and evaluate a coordinated and comprehensive system of long-term care services, including technical assistance, alternative sources of financing, non-institutional placement alternatives and a consistent definition of roles and responsibilities for all levels of government and private organizations in the planning, administration and financing of long-term care services. The other directed the state to provide a report on hospice services, including an assessment of cost savings that may result from providing hospice services to persons who would otherwise use hospitals, nursing homes or more expensive care. The hospice benefit will be terminated on April 1, 1990 unless it is extended by the legislature. Amendments to the state Medicaid plan are called for to expand optional long-term care services. The legislation also expands agencies with which Medicaid may contract with for respite care services and adds a section to evaluate the mental and physical ability of the caregiver to perform necessary caregiver functions. Like Washington, Oregon created the "Oregon Disabilities Commission" to develop a long range plan for programs and services to the disabled population and amended current law to require that certified or accredited hospices need a license to operate if they meet the definition of a home health agency and receive direct compensation for home health care services form the patient, insurers, Medicare or Medicaid.

C. Maternal and Child Health:

Outreach efforts to facilitate and coordinate Medicaid program entry and eligibility determination for pregnant women and children received much notoriety in state legislatures this year and are outlined in the state profiles. For example, a new California law allows counties to petition the state to place Medi-Cal eligibility workers at alternative sites (e.g., clinics) to facilitate the receipt and processing of applications for Medi-Cal eligibility for pregnant women. It also requires the state to report to the legislature on the feasibility of implementing a common eligibility procedure and uniform eligibility standard for programs delivering services to pregnant women, and women with infants and young children as well as programs for children and adolescents. The report must cover programs that currently provide nutritional supplements, immunizations, health education and other services as decided by the department. In a similar step, the Iowa legislature required the state to provide technical assistance to other state agencies to develop outreach centers to provide and coordinate public services to pregnant women. The Indiana legislature now requires

an annual evaluation of effectiveness of expanding services to pregnant women and children up to 3 years of age.

D. Prescription Drugs:

In anticipation of implementing the prescription drug benefit under the Medicare Catastrophic Coverage Act, a number of states enacted laws to solidify the administration and control utilization (and therefore the costs) of prescription drugs.* For example, under a new law in **Iowa,** the state must adopt rules for ICFs to execute separate written contracts for pharmaceutical vendor services and consultant pharmacists. The contract must require monthly drug regimen review reports, and reimbursement will be based on fair market value. The state is also directed to study possible certification of consultant pharmacists. **Indiana** has set up an advisory committee to participate in the AMA's drug diversion program (PADS II). The advisory committee on controlled substances must issue a written report to the General Assembly before October 1 of each year containing information on multiple copy prescriptions and the number of actions taken against a practitioner as a result of participation in the PADS program. To control costs, New **Mexico** has limited the estimated acquisition cost of a drug to the average wholesale price less 10.5%. **California** enacted a law that allows a drug manufacturer to submit alternative documentation to the FDA Summary Basis of Approval in order to have a drug added to the state formulary. The legislation also establishes special treatment authorization request process that allows physicians to prescribe a single-source drug under certain circumstances when the drug has been removed from the Medi-Cal formulary.

Finally, 2 states -- **Connecticut** and South Carolina --are studying new ways to finance and control utilization of prescription drugs. New legislation in Connecticut requires the state to (1) study the reasonableness of the state's payments for Medicaid drugs, including a generic incentive dispensing fee; (2) review prescription drug utilization by therapeutic category under Medicaid; (3) outline problems in administering the Medicaid prescription drug program, suggest solutions and make recommendations for system improvements; and (4) study the feasibility of implementing state limited high-volume drug formulary and pharmaceutical rebate programs. **South Carolina** directed its efforts towards a study of reimbursement methodology for pharmacy providers who serve a disproportionate share of Medicaid recipients.

E. Medicaid Management Information Systems (MMIS):

California, Connecticut, Indiana, Iowa and Wyoming -- directed the state Medicaid agencies to improve their Medicaid Management Information Systems (MMIS) systems to better track program beneficiaries in order to improve state planning efforts. **California's law requires** the state to develop a system that would inform Medi-Cal providers whether a beneficiary is eligible to receive case-management services for all non-emergency services. Once established, if the system fails to inform a provider that the beneficiary is subject to case management, the provider will be reimbursed for such services. Similarly, Connecticut enacted legislation that requires development of an

[2]The prescription drug benefit, along with most other provisions, was repealed under the Medicare Catastrophic Coverage Act of 1989 (P.L. 101-234).

information system to track data on a broad number of programs, including those providing services to pregnant women and children, nursing home residents, AFDC and General Assistance recipients as well as on nursing home reforms mandated by OBRA-87 and savings attributed to the Medicare Catastrophic Coverage Act of 1988 and the "Job Opportunities and Basic Skills Training" program. The system will also track economic indicators as well as rate and volume measures useful in projecting public assistance expenditures. An **Indiana** law requires the state to develop either a 24-hour telephone system or computerized information system to give providers immediate access to information to determine if an individual is eligible for medical assistance. **Iowa** is now required to make use of its MMIS to identify Medicaid children in need of preventive health services and to review and evaluate birth outcomes of children born to Medicaid-eligible mothers; and **Wyoming** passed legislation to implement MMIS effective July 31, 1989.

F. Fraud, Recovery and Third Party Liability:

Cost-containment directives have led a number of states to increase their efforts to realize program savings by developing more stringent penalties for fraud and abuse, increasing recovery activities and enforcing third-party liability regulations.

Fraud: Six states enacted Medicaid fraud legislation this session. Both **Oklahoma** and New **Mexico** passed laws that empower the attorneys general, the district attorneys, the Medicaid Providers Fraud Control Unit and the Department of Human Services to investigate, and prosecute if they have such authority, violations under the Medicaid Fraud Act. **Louisiana** increased the penalty for Medicaid fraud to a maximum fine of $10,000 and a maximum jail sentence of up to 5 years. **Oregon** relaxed laws for cases that involve Medicaid funds in 2 or more counties by allowing the trial to be held in either the county in which the claim was submitted or the county in which the claim was paid. **Rhode Island** reduced the time period from 40 to 20 days that an individual may appeal a Medicaid fraud demand to the state superior court and further defined and clarified fraudulent acts under the Medicaid. Finally, a new **Utah** law now requires its Medicaid agency to establish rules, measures and sanctions for Medicaid providers who fail to comply with rules and procedures of the program. Funds collected as a result of sanctions shall be deposited in the General Fund as nonlapsing dedicated credits for the department's use.

Recovery: Legislative action to step up recovery activities took place in at least 9 states. **Arizona** now allows prepaid capitated providers to conduct postpayment review of claims and to recoup monies erroneously paid. The legislation also requires AHCCCS (the Arizona Health Care Cost Containment System -- the state's Medicaid program) to recover funds that result from inaccurate eligibility determination. Taking a different approach, **Colorado** requires its Medicaid agency to report to the Department of Revenue the name, Social Security number and the amount owed of any recipient who is obligated to the state for overpayment. It also authorizes the district attorney to obtain from the department any information that will lead to location of individuals who have fraudulently obtained services under Medicaid. A similar strategy will be used this year in **Iowa** by allowing the state Medicaid agency to recover payment for medical services to a Medicaid recipient in the event that the Medicaid recipient wins a settlement, award or judgement against a third party. **Massachusetts** increased by 10% (from 15% to 25%) the amount of money that can be deducted from monthly payments to a provider in the event of overpayment.

California and **Maine** enacted legislation concerning estate recovery. The **California** law requires the state to waive its claim for Medi-Cal services against the estate of a decedent or the recipient of property of that decedent, if enforcement of the claim would result in substantial hardship to other dependents of the individual against whose estate the claim exists. **Maine** authorized the state to seek claims against the estate of Medicaid recipients after their deaths when new payments or other assets are discovered that would have made the person ineligible for medical assistance. It also revises the state's authority for collecting debts owed by nursing homes, particularly when ownership has changed. Finally, 3 states -- Michigan, Missouri and **Ohio** -- set rules and standards for recovery procedures. As part of a major cost-containment effort, the Michigan Medicaid agency is also required to submit quarterly reports on the progress being made to implement and produce savings from recovery efforts.

Third Party Liability: Three states expanded their authority to use liens in order to recover Medicaid funds. A new law in **Nevada** stipulates that if the state's welfare division receives a notice from a medical assistance beneficiary of intent to settle or commence action to enforce legal liability for medical costs, the division may reduce any lien on the proceeds of a recovery to expedite the process. The legislation prohibits the recipient's attorney from conditioning the amount of the attorney's fees or imposing additional fees based on whether or not there is a reduction of the lien. Montana has also established more stringent third-party recovery actions, primarily through the use of liens. Legislation was enacted in Utah that allows the state to recover costs of medical assistance from a third party if the state has provided assistance under Medicaid or Medicare to individuals for which a third party is responsible. The department may place a lien on proceeds payable to that third party. The definition of "third party" was also expanded to include trusts, estates, PPOs, CHAMPUS, workers' compensation and a spouse or parent who has been appointed by the court to maintain a recipient's health, dental or disability insurance. The legislation also sets criteria for enforcing the lien. An unrelated California law now requires Medi-Cal to recover third-party liability for the cost of targeted case management services It also directs the state to study and enhance efforts to reduce the eligibility rate by 0.5% and to increase third party liability collections by 10%.

V. MEDICAID-RELATED STRATEGIES

A. AIDS:

California enacted a series of laws in 1989 aimed at improving services to individuals with AIDS or AIDS-related health problems. The initiatives include: (1) a study of problems concerning the distribution of health care for AIDS patients in hospitals in major metropolitan areas; (2) a feasibility study on the coordination of various levels of health care within one program in a city or county to serve persons with HIV infection, ARC and AIDS; (3) a two-year prospective study of the medical costs of AIDS. The study will compare inpatient and outpatient services, physician services and community support services and will also include cost factors in the review of inpatient costs that may not be apparent in the analysis of charges, such as private rooms and social work; (4) a report to the legislature on the various federal waivers for HIV- and drug-exposed foster children; and (5) a program to provide early intervention

and long-term care services to persons infected with HIV, including education and the coordination of services.

Three other states -- Colorado, Montana, and Virginia -- are investigating the use of Home and Community-Based Services (HCBS) Waivers available under OBRA-81 (Section 2176) to assist AIDS patients. Montana's program which became operational July 1, 1989 provides home-based treatment to eligible recipients with AIDS or disabling ARC who would otherwise require hospitalization. The first-year projections estimate that services will be provided to a maximum of 298 recipients. Services include: (1) attendant care; (2) private-duty nursing; (3) supplies such as gloves, diapers and underpads--items that are not available under the state plan program; and (4) non-emergency transportation. In addition, Indiana is requesting a waiver to provide case management services to individuals with AIDS and AIDS-related conditions under Medicaid.

The state of Washington directed its Medicaid agency to request a waiver under Section 1915(c), a waiver for the aged available under OBRA-87 to provide community-based long-term care services to individuals with AIDS or AIDS-related conditions who qualify for (a) Medicaid or (b) the limited casualty program for the medically needy. Respite care services will be included as a service available under the waiver. This type of waiver program is designed to address long-term care needs in states that have restrained nursing home construction. Generally, the number of participants in a HCBS waiver is limited to the number of individuals who would actually occupy a Medicaid nursing home bed in the absence of the waiver.

A two-year pilot program, implemented in Michigan in October, will assist certain individuals who are at risk of losing their health insurance because of AIDS related disease. Colorado and Washington are developing programs to use options under COBRA to expand health insurance to AIDS patients. The provision requires that for workers terminated under certain conditions, employers must either continue an employee's group health insurance or convert the person's group coverage to an individual policy. The Colorado law sets up a two-year pilot project for certain AIDS victims to access health insurance under COBRA. The Washington plan allows the state to use Medicaid funds to pay for health insurance coverage for persons with Class IV HIV infection who meet Medicaid eligibility requirements and are eligible for coverage under COBRA. In other initiatives, Indiana will provide resources to a nonprofit AIDS service organization to develop community action groups, coordinate information gathering and develop a model for provision of integrated services to HIV population. And Wisconsin has established a program for individuals in need of AZT who are (1) infected with HIV; (2) have less than $40,000 per year in income; and (3) are not eligible for Medicaid.

B. Maternal and Child Health:

Several states developed programs to promote program coordination and improve access to prenatal care services, particularly for women at risk of complicated pregnancies or low birthweight babies. For example, the Iowa Department of Public Health was directed to provide technical assistance to encourage coordination with the Department of Health Services in providing care to pregnant women and children as well as to expand successful interagency projects currently operating in Ottumwa and Sioux City that provide clients with a single point to obtain maternal and child

health services, WIC, food stamps, and Medicaid. **Montana** developed a prenatal care demonstration project and advisory council to reduce infant mortality and low birthweight by expanding access to public assistance and educational programs and providing outreach and referral services. The project will coordinate with existing programs, including EPSDT, Medicaid and the federal Maternal and Child Health Services Block Grant. **North Carolina** has initiated a similar program for low-income women on a statewide basis.

As part of the state's efforts to improve access to prenatal care under the "Maternity Care Access Act of 1989," the Washington legislature required the state to have a number of procedures to make the eligibility application and determination process faster, easier and more accessible to the target populations. In addition, the state also established case management services targeted to certain high-risk, low-income pregnant women, such as teens and chemically-dependent pregnant women. Services will include transportation, child care, psycho-social counseling and education, nutritional counseling, preventive services provided in the home and post-delivery services.

C. Long-Term Care:

Long-Term Care Insurance: As long-term care services continue to require an increasing percentage of the Medicaid budget, states are looking towards innovations in long-term care insurance to decrease dependence on state financing for this type of care. Five states -- California, Connecticut, **Kansas, Massachusetts** and New York -- authorized demonstration projects to test the feasibility of long-term care insurance. California directs its Medicaid program to pay private insurance premiums for participants in the state's pilot projects assessing the cost-effectiveness of home health, attendant and hospice care. Such premiums will only be paid where they are shown to be cost-effective. The state also authorized the Department of Health to establish 5 demonstration projects for the purpose of developing risk-based capitated long-term care pilot programs.

Connecticut, taking a more private sector approach, established a six-year pilot program called the "Connecticut Partnership for Long-Term Care." Under this program, individuals may purchase private long-term care insurance that will pay for nursing home and home care services and protect some of their assets if they eventually need Medicaid assistance. Individuals may purchase insurance in an amount commensurate with assets, and people who buy or renew the precertified policy during the pilot period (1/1/90 through 12/31/94) will receive asset protection for life. Electing yet another approach to this problem, Massachusetts directed its state Department of Public Welfare to study the feasibility of creating a long-term care trust fund as a supplement or alternative to the long-term care Medicaid program currently in effect. The Trust Fund, jointly financed by subscriber contributions and state appropriations, would provide non-means tested, time limited, long-term care health insurance coverage to all Massachusetts citizens who have contributed to the fund, are over 65 years of age, are in need of long-term care services, whether institutional or home-based, and receive services from qualified providers.

Home Health Services: **Colorado** and New **York** are applying for Home and Community Based Waivers to serve young persons with developmental disabilities. Furthermore, under the **Kansas** "Senior Care Act," the Secretary on Aging is authorized

to establish in-home services for state residents over 60 years of age who have functional disabilities that restrict their ability to live independently. The Secretary is directed to designate Area Agencies on Aging to administer the program after an agency has submitted an acceptable program plan. Taking a different approach to home health care, the state of **Indiana** was directed to request a federal waiver before January 1, 1990 to reimburse relatives of Medicaid eligibles trained to provide homemaker and personal care services. The program would be limited to Medicaid recipients for whom provision of care results in financial hardship for the relative. New **York is extending** the state's authority to establish demonstration projects for the delivery of long-term care home health services until June 30, 1990.

D. Mental Health:

States took a variety actions in the mental health arena in 1989. Some laws were directed at children's services, such as in **Iowa** and Michigan, while other laws were broader in scope. The state of **Iowa is** now required to assess the number and. location of children who need the services of a psychiatric medical institution and make recommendations on limiting the number of children's psychiatric medical beds. A similar law in Michigan authorized the state to study the feasibility of covering psychological services for acutely and chronically ill, abused, neglected and delinquent children and their families under the Medicaid program. Based upon this evaluation, the state may expand Medicaid coverage to include these services on or after April 1, 1990 if no additional state general fund costs for these services are projected and if appropriate utilization controls are implemented.

The Missouri legislature authorized the department to seek a waiver to provide psychiatric rehabilitation services to those individuals who are found through assessment to be seriously and persistently mentally ill, in order to maintain them in a community setting, while Montana focused on residential treatment services by establishing a two-year pilot project for Medicaid reimbursement of inpatient psychiatric services. Utah also provided its Medicaid department the authority to secure a HCFA waiver and to issue a "Request For Proposal" for the provision of mental health services to Medicaid clients under a capitated funding plan. The contractors would be free to provide necessary mental health and psychiatric services to all enrollees. In an effort to coordinate services, the state of Virginia directed an interagency study of substance abuse treatment services to persons who are eligible for medical assistance to be conducted jointly by the Department of Medical Assistance Services and the Department of Mental Health, Mental Retardation and Substance Abuse Services.

E. Other State Initiatives:

Oregon's "Priority List": Clearly, the most innovative and controversial piece of legislation affecting Medicaid in 1989 is an Oregon law that calls for a radical restructuring of the state's Medicaid program. This law establishes a Health Services Commission to determine, through a series of meetings, forums and public hearings, a prioritized list of medical services that will be made available to recipients under the program. The number of services offered will be determined by the availability of funds, and all services on the list that are provided must be made available in full scope (also determined by the commission) to all recipients. If insufficient funds are available for all services on the list, services will be eliminated in order of least

importance. The concept behind this method is that in the absence of adequate resources, the state would prefer to reduce the types of services available rather than eligibility standards for participants or reimbursement rates for providers. In order to implement the program, the Adult and Family Services Division (the administering agency) must obtain federal waivers that would: (1) expand eligibility to all people below the federal poverty level regardless of family status (currently single and childless couples are not eligible for Medicaid); and (2) possibly exclude certain categories of hospital and physician services that are required under Medicaid. The understanding is that some minimum level of benefits will be required under the federal waiver as a condition of the program; however, it is not clear exactly what configuration of services it will include. At the time of this writing, no federal waivers have been granted for this program.

Another **Oregon** law reorganized services for the disabled by transferring responsibility from the Adult and Family Services Division, which is responsible for Medicaid, to the Senior and Disabled Services Division (SDSD). The goals are to develop through local Area Agencies on Aging a comprehensive and integrated system for delivery of services to the disabled population, to assist these agencies to stimulate more effective use of existing resources and to develop programs, opportunities and services not otherwise provided to the disabled population.

Delaware's "Healthy Lifestyles" Health Insurance Certification Plan: Another innovative health insurance law was developed by the **Delaware** Department of Insurance. In order for a health insurance plan to be certified by the state Insurance Commission, it must provide the following: (1) economic incentives and disincentives substantial enough to encourage policy holders to modify their behavior; (2) significant economic disincentives and penalties to policyholders who falsely certify participation in the practice of health lifestyle behaviors that reduce health care claims; and (3) benefits for appropriate preventive health screenings and adult immunizations as recommended by the Delaware Department of Public Health. Delaware is the first state in the country to establish this type of Insurance Commissioner-certified health insurance program.

New York's Eligibility Demonstration Project: This law authorizes the state to conduct an eligibility demonstration project to test the benefits of expanding Medicaid participation to uninsured individuals who are currently excluded because of the income requirements. The project will allow individuals who meet eligibility criteria for medical assistance except for having incomes that exceed the eligibility standard to become eligible by paying their local social service office the amount by which their income exceeds the threshold.

Vermont's Pharmaceutical Assistance for Elderly & Disabled: Vermont established a pharmaceutical assistance program for elderly and disabled individuals to provide access to necessary prescription drugs and promote efficiency and effectiveness through cost controls and utilization review. The program involves cooperation among several state agencies, including the Department of Social Welfare, the Office of Aging and the Commissioner of Taxes. Coverage will be set by Department of Social Welfare rules and will require copayments. Individuals who are at least 65 years of age or disabled and whose family incomes are less than **175%** of the federal poverty level are eligible to participate in the program.

HIGHLIGHTS AND TRENDS IN STATE PROGRAMS

FOR THE INDIGENT AND UNINSURED, 1989

Health care services for the uninsured and individuals not eligible for Medicaid or other public assistance programs received attention on a number of fronts this year. Most notable was the "Gap Group" legislation enacted in **Hawaii,** making it the first (and only) state in the nation to potentially close all the holes in the web of private and public programs that provide access to care. **California** also established several new indigent care programs using funds from the state's new "Cigarette and Tobacco Products Surtax Fund." In addition, vulnerable populations such as pregnant women and children, the disabled and the very poor were primary targets for program expansions in other states,

Ensuring access to care, however, requires more than simply enrolling clients in a program. Shortages of providers willing to accept lower reimbursement rates, coupled with the high cost of malpractice insurance and an uncompensated care debt that is increasingly concentrated on particular providers, have exacerbated access to both hospital and physician services. A number of states have consequently taken steps to encourage providers to participate in public programs by subsidizing malpractice insurance, offering loan forgiveness programs in exchange for practicing in underserved areas and increasing reimbursement rates to relieve some of the pressure put on providers by a growing uncompensated care debt.

Taking another tack, state governments are also attempting to leverage private support for health insurance for the working poor through employer-based strategies. These strategies, which are targeted primarily for small businesses, include using tax credits, direct subsidies and Multiple Employer Trusts (METS); regulating insurance plans; and developing affordable insurance products for small businesses and individuals. States are also experimenting with the "play or pay" approach, which requires employers who do not participate in a state plan to pay a fee to support an insurance pool for the uninsured. Finally, states are also continuing to search for viable solutions by using commissions and task forces to examine the issues.

A. Pregnant Women and Infants:

While the network of maternal and child health programs is large, gaps in services still exist despite recent expansions of Medicaid coverage. In response to well-documented inadequacies, states have recently undertaken a number of significant initiatives in the areas of prenatal care for indigent and low-income women.

Five states established programs to improve access, expand the breadth of services available and increase coordination of prenatal care among the myriad groups that provide such services. A new program in New Jersey called "Jersey MOMS" (Maternal Outreach and Managed Services) now offers a comprehensive package of prenatal health care and support services to any women seeking such care. The package will include case coordination, health education, nutrition education and assistance coordinated through the WIC program, social/psychological assessment and counseling, home visits when necessary and referral to and follow-up with other appropriate health care providers. Under the program, women with incomes below 150% of poverty will

receive the entire package at no cost; those with incomes between 150% and 250% of poverty will be asked to pay according to a sliding-fee scale. Others can purchase the services at already established rates.

Rhode Island established a new program covering maternity services for indigent pregnant women whose income is below 185% of the federal poverty level. The program includes referral for non-covered services, care coordination, nutrition and social service counseling, high-risk obstetrical care, childbirth and parenting preparation, smoking cessation counseling, outpatient counseling for substance abuse and interpreter services. In addition, through its "Maternity Care Access Act of 1989," **Washington also** established a program to improve access to prenatal care services for low-income women and children in poverty (see Medicaid: Benefits and Related Strategies). Similarly, **Vermont** created a new program using state-only funds to extend prenatal care to pregnant women with incomes between 185% and 200% of the federal poverty level who do not have health insurance coverage for such care.

Oklahoma appropriated $950,000 for the provision of perinatal services to low-income women statewide to be used primarily for services to high-risk pregnant women in unserved or underserved counties and to encourage early entry of high-risk clients into the health care system. The funds will also be used to establish a demonstration program for preventive and comprehensive prenatal care services to be located in a select county with a high teen pregnancy rate. Services will include ambulatory care, community organizing and case management, social work and nutrition, public education and follow-up services.

B. Children's Services:

Like prenatal care, basic health services for children, such as immunizations and well-child check-ups, also present serious problems. While Medicaid expansions have increased coverage for children's services, almost half of all poor children are left without access to care. Consequently, a number of states focused on health care for children in their 1989 sessions.

Maine created the "Maine Health Program," which is intended to meet the health care needs of uninsured residents who are not eligible for Medicaid, placing a special priority on low-income children. Eligibility is extended to children under 18 years of age with family incomes at or below 125% of poverty and to persons age 18 or older with household incomes at or below 95% of poverty (scheduled to increase to 100% in July of 1992). A contribution to program premiums may be required for individuals with family incomes over 100% of poverty but fees may not exceed 3% of the household income. Recipients will receive the same range of benefits as Medicaid recipients, and state officials estimate program participation at approximately 13,000 individuals.

Three states increased children's health programs by expanding eligibility standards. **Vermont** extended medical benefits for children through age 6 whose family incomes are less than 225% of the federal poverty level and who do not have health insurance. A small copayment is charged for well-child visits. **Vermont is the first** state to cover children in families with incomes over 200% of poverty. In a similar move, **Minnesota expanded** the Children's Health Plan to include coverage of children between the ages of 9 and 18 as of January 1, 1990 and add coverage of mental health services as of July 1, 1990. The Children's Health Plan was established in 1988 and

provides ambulatory health care to children whose family income is at or below 185% of the federal poverty level. **Arkansas** also established a program for the provision of services to uninsured children whose gross family income does not exceed 185% of poverty and who are not covered by Medicaid or other public assistance programs.

Two states are expanding services by leveraging private sector dollars. Iowa set up a matching grants program for charitable and non-profit organizations to develop programs to provide health insurance coverage of primary care and preventative services to uninsured children. The organizations' grant program must coordinate with existing public programs; in order to receive state matching funds, the contract organizations must raise $2 for every state dollar in 1990, $3 for every state dollar in 1991 and $4 for every state dollar in 1992. Taking a somewhat different approach, **Alabama set up a "Penny Trust Fund" to which individuals may** make voluntary contributions; funds will be divided between programs to reduce infant mortality, improve children's health and implement prevention and health promotion programs in public schools.

C. Provider Participation:

Assuring adequate provider participation in both rural and non-rural areas has been a perennial concern for public health programs. This year, three states -- Louisiana, Michigan, and Texas -- enacted legislation to reduce providers' malpractice liability to encourage program participation.

Both Michigan and Texas now provide direct subsidies in exchange for services to indigents. Michigan now makes available up to $8,000 to pay the cost of medical liability insurance for those professionals who participate in the uncompensated health care project of the Wayne County and Detroit medical societies. The Texas legislature directed the state to assume liability for medical malpractice claims against health care professionals who provide at least 10% charity care during the insurance policy year. Charity care is defined to include the state indigent care program, Medicaid, the Maternal and Child Health program, care for chronically ill children, the primary health care and migrant health programs. Eligible providers must still maintain malpractice insurance, but may qualify for a premium discount. The state of Louisiana also provides protection for all health care providers who treat patients referred by a state hospital or other state facility when treatment is provided without compensation or reimbursement from any state or federal public assistance program.

Another approach followed by some states to increase access to care for indigents involves encouraging providers to locate in designated underserved areas through educational scholarships and loan forgiveness programs. One such example is Tennessee, which established a "Health Access Incentive Account." Under this program, the Department of Health and Environment will assist in recruiting health professionals to provide services, including funding primary care residency rotations, reimbursing travel for potential practitioners and developing a computerized tracking system to monitor and evaluate recruitment activities. Other examples include a new program in Oregon, the "Rural Health Services Program," for physicians and nurse practitioners who agree to practice in medically underserved rural communities; Washington's loan repayment program authorized under the "Maternity Care Access Act of 1989;" and the "Local Availability Project" (LAP) in West Virginia that offers

obstetrical services to low-income pregnant women in counties with a shortage of providers.

D. Uncompensated Hospital Care:

Hospitals often cite the financial pressure of uncompensated care as a major impediment to serving indigent patients. Three states -- **Maine, Rhode Island and Virginia --established** new uncompensated care programs to assist financially distressed hospitals and those that are most affected by bad debt, charity care and shortfalls in government payments.

Funds for **Maine's** program, the "Hospital Uncompensated Care and Governmental Payment Shortfall Fund," will come from general state revenues and from assessments on all hospitals. **Rhode Island** appropriated $1.5 million for its uncompensated care grant program for financially distressed hospitals and specified 15 hospitals for participation. The program has a sunset date of June 30, 1990. Virginia also established the an "Indigent Health Care Trust Fund" within the Department of Medical Assistance Services, that will pay for charity care provided by hospitals. Funds will come from state general revenues and contributions from hospitals.

Under a new law, Florida now allows psychiatric hospitals to provide acute mental health services to indigent mentally ill persons and gain access to the state's hospital uncompensated care fund (the "Public Medical Assistance Trust Fund" or PMATF) for reimbursement. The fund is supported by a hospital revenue tax, and the amount available to such hospitals may not exceed the amount they contributed to the PMATF in the previous year. The state also established the "Florida Commission for the Funding of Indigent Health Care" to review the use of funds from the PMATF.

Other states using commissions or committees to review hospital uncompensated care funding include Louisiana, New Jersey and Rhode Island. Louisiana created the "Louisiana Health Care Authority" to develop a comprehensive plan to revitalize the facilities and services of the state's charity care hospital system. Likewise, Rhode Island established a 19-member Blue Ribbon Commission to study hospital financing and uncompensated care, devise a system to meet the need of the state's residents and develop policy recommendations to ensure continued delivery of comprehensive and cost-effective hospital services.

The New Jersey legislature directed the state's Uncompensated Care Trust Fund Advisory Committee to review the methodology and assumptions used to establish the statewide uncompensated care add-on, make recommendations on the procedures that shall be used to audit uncompensated care at the hospitals and explore various initiatives to reduce the amount of uncompensated care. The committee must also analyze the possible impact of increased unemployment on the amount of uncompensated care provided by hospitals.

E. Employer-Based Strategies:

Recent studies indicate that over two-thirds of those without health insurance are tied to the workforce either through direct employment or through a working family member. In addition, budget constraints and an increasing number of federal

mandates continue to stress state programs that provide health coverage for indigents and the uninsured. As a result, a number of states are exploring ways to increase private sector coverage through the more traditional employer-based health insurance system. A number of strategies are being employed, including direct subsidies for small employers, tax credits and state mandates.

Oregon expanded health insurance coverage for low-wage workers in small firms or firms with a large number of low-wage workers by subsidizing employers' premiums both directly and indirectly through a tax credit. Under the state subsidy, employers will provide coverage similar to the list of services developed under the priority list by the Health Services Commission (see Medicaid-Related Strategies). The employer subsidy plan is limited to those employers with no more than 25 employees who do not have health insurance through a family member or other sources. Employers are required to pay a maximum of $40 per month toward each eligible employee's premium. The employer may require a minimum contribution by the employee of up to 25% of the premium or $15, whichever is less. All employers eligible for the state subsidy will be allowed a tax credit to be the lesser of (1) 50% of the total amount paid during the taxable year; or (2) the following tax credit schedule--$25 per eligible per month in 1989 and 1990, $18.75 in 1991, $12.50 in 1992 and $6.25 in 1993. The program will be evaluated on an annual basis, and depending upon the number of workers enrolled, the tax credit rate will be maintained at the same level as the previous year or the original reduction schedule (as mentioned above) will be applied.

Vermont lawmakers are looking to more stringent regulations of the insurance industry in hopes of expanding access of the working poor to private health insurance. Legislation enacted this year prohibits insurers from excluding part-time employees from group health insurance plans. The statutes now requires insurers to offer the same group health benefits to part-time employees that it offers to employee groups that the part-timers would be part of if they were full-time workers. The premium will be paid in full by either the employer or the employee, or through a pro-rated rate, with cost sharing between the employer and the employee. "Part-time" is defined as any employee who works a minimum of 17 1/2 hours per week.

Another Vermont law directs the state's Health Insurance Plan Board to design a small business partnership program and an individual health insurance program building upon existing public and private health care services. The Board must also establish a technical assistance program in conjunction with the private and non-profit sectors to help employers locate, evaluate and administer health insurance benefits for their employees. Similarly, Iowa also now requires the state's insurance division to develop a proposal to provide technical assistance to small employers to identify, access and evaluate Multiple Employer Trusts (METS) within the state and to assist small employers in overcoming barriers to participating in state METS.

Two states -- California and Nebraska -- are studying the possibility of using employer mandates to cover the working uninsured, California established a statewide statutory framework for mandating that employers with 5 or more workers offer a minimum package of health insurance benefits. Benefits include inpatient and outpatient hospital care, physician services, maternity care and mental health services not attributable to substance abuse. The legislation also created a task force to study the feasibility of mandating employer-based benefits. The plan is scheduled to go into effect in 1992, subject to the recommendations of the task force. Nebraska directed

the Health and Human Services Committee to conduct an interim study of the effectiveness of incentives for businesses to provide health insurance coverage for their employees and the feasibility of establishing an employer-based insurance pool for the working uninsured.

F. State Health Insurance:

While a few states have taken great strides in the direction of universal coverage and several others are debating the issue, Hawaii is the only state that can lay claim to almost full health insurance coverage for all its residents. In the 1989, **Hawaii** enacted its "Gap Group" legislation to protect the remaining 4% estimated to be uninsured in 1988. This new program will cover those individuals that do not qualify for health insurance under any of the existing public programs and do not have access to health insurance through the private system. The state has appropriated $4 million for FY 1989-90 and $10 million for FY 1990-91.

In an interesting step, **West** Virginia established the "West Virginia Health Care Insurance Fund," a state pool demonstration project for individuals without insurance, that will use the public employees' insurance agency. This will be accomplished by pooling in a group both small businesses that do not offer insurance and "uninsurable?, (those individuals who are unable to obtain insurance generally because of a pre-existing condition). This new program is to cooperate with the state Medicaid agency to avoid an overlap in eligible persons and also to use alternative coverage models used under Medicaid (i.e., work transition) in the new plan. The plan will begin as a three-year pilot with at least 2,000 enrollees, with reports due to the legislature in 1990, 1991 and 1992.

Iowa also established a statutory framework for the provision of a health care insurance plan and pool within the state treasury to provide and fund primary and preventive health insurance to uninsured residents. The effective date is dependent upon enactment of a funding mechanism and detailing responsibilities of the state and employer participation. Using Massachusetts "play or pay" scheme, Oregon also created a state insurance pool to increase access to the working uninsured. The pool will be funded by employers who do not participate in the state subsidy plan mentioned above and who do not offer coverage to their workers. The Insurance Pool may exempt employers due to hardship and fix the terms and conditions of the exemptions.

G. State Risk Pools:

Three states -- **Georgia,** South **Carolina** and Texas -- created state risk pools to provide health insurance for individuals who cannot obtain coverage through other sources. Legislation in all three states establishes a governing board, specifies membership on the board and designates rules and procedures for operation. The laws also specify eligibility and coverage requirements.

Financing and other requirements for the state risk pools varies: Georgia's "High Risk Health Insurance Plan" will be financed through appropriations and public and private contributions. The law becomes effective on July 1, 1989 only to appoint the commission and establish elements of the plan by the governing board. The rest of

the Act will become effective upon state appropriations for the pool. In South **Carolina,** the pool will be financed by a tax on insurers but contains a tax credit for participating insurers. The insurer will be selected through a competitive bidding process. The program excludes individuals covered under Medicaid, Medicare or other public programs, AIDS patients and those for whom the pool has paid out $250,000 in benefits. The **Texas** legislation requires that the pool sets rates between 150% and 200% of rates applicable to individual standard risks. This state pool will be financed through state appropriations; however, if insufficient funds are available to support the pool, the insurance board may levy a tax on insurers operating in the state.

Nebraska directed the State Health and Human Services Committee and the State Insurance Pool Banking, Commerce and Insurance Committee of the Legislature to conduct an interim study to examine issues associated the "Comprehensive Health Insurance Pool" (CHIP) program. The study will include but not be limited to CHIP's financial status; cost-containment; current and projected utilization; rate setting methodology for CHIP premiums; current and alternative funding sources for the pool; eligibility for membership; management of the pool; and the need for change in federal laws, rules and regulations that adversely affect the program.

H. **Studies, Task Forces and Commissions:**

Studies on indigent care were mandated by 6 states this year, including Delaware, Georgia, Louisiana, New Hampshire, South Dakota and Virginia. In an omnibus approach to the problem, **Delaware** requested the Department of Health and Social Services to review strategies such as implementing tax credits and incentives; expanding Medicaid coverage; limiting malpractice liability; developing uniform minimum benefits under current state insurance regulations; and standardizing reimbursement levels for all payers based on an expanded version of the DRG system.

Georgia created the an "Access to Health Care Commission" to review existing laws and programs, including Medicaid, develop alternatives for removing barriers to access and hold public hearings. Louisiana also created an "Indigent Health Care Trust Fund Authority" to study and develop a comprehensive plan to improve access to health care for indigent residents. New Hampshire established a committee to conduct a survey to measure the nature and extent of the state's health care access problem and to develop a legislative proposal for a program that would increase the availability of basic health coverage for low-income residents. And both South **Dakota and Virginia resolved to continue investigating** issues related to access for indigent populations.

In addition, Connecticut established a "Blue Ribbon Commission on State Health Insurance" to develop a comprehensive and universal state health insurance program and consider various methods to fund uncompensated and undercompensated care in hospitals. In principal, a universal state health insurance plan should: (1) be available to all individuals in the state, regardless of disability or pre-existing conditions, who do not have employer-sponsored benefits or whose premiums under such a plan exceed the payments which would be required under the state plan; (2) be administered by the state and use a sliding fee scale based on household income and family size to set premiums; and (3) provide comprehensive coverage including inpatient, outpatient hospital and physician services, preventive and rehabilitation services and mental health services. Rhode Island further extended the reporting date for its study of

universal health insurance (established by HR 244 in 1988) until February of 1991 and will study the feasibility of establishing universal health insurance in the state. Other commissions were established to study access to services for the homeless **(Kansas)** and general health issues including cost-containment, source of financing, alternative strategies for service provision, long-term care, AIDS, mental health and services to disabled individuals **(North Dakota** and **Nebraska).**

ABBREVIATIONS

TOPIC

AAA: *Area Agencies on Aging*
ABC: *Adjusted Bill Charges*
AFDC: *Aid to Families with Dependent Children*
AIDS: *Acquired Immune Deficiency Syndrome*
CBS: *Community-Based Services*
CMHC: *Community Mental Health Center*
CN: Categorically Needy
COBRA: *Consolidated Omnibus Budget Reconciliation Act of 1985*
COLA: *Cost-of-Living Adjustment*
CON: Certificate of Need
CPI: *Consumer Price Index*
DD: *Developmentally Disabled*
DEPARTMENT: *State Medicaid Agency or Department in which it is housed*
DHHS: U.S. *Department of Health and Human Services*
DME: *Durable Medical Equipment*
DRG: *Diagnosis-Related Group*
DSH: *Disproportionate Share Hospitals*
EMS: *Emergency Services*
EPSDT: *Early and Periodic Screening, Diagnosis and Treatment*
ESRD: *End Stage Rena/ Disease*
ER: *Emergency Room*
FFS: *Fee-For-Service*
FPL: *Federal Poverty Level*
FY: *Fiscal Year*
GA: Genera/ Assistance
HCBS: *Home and Community Based Services*
HCFA: *Health Care Financing Administration*
HHA: *Home Health Agency*
HIO: *Health Insuring Organization*
HMO: *Health Maintenance Organization*
ICF: *Intermediate Care Facility*
ICF/DD: *Intermediate Care Facility for the Developmentally Disabled*
ICF/MR: *Intermediate Care Facility for the Mentally Retarded*
LOS: *Length of Stay*
LTC: *Long Term Care*
MCCA: *Medicare Catastrophic Coverage Act of 1988*
MMIS: *Medicaid Management Information System*
MN: *Medically Needy*
MNIL: *Medically Needy Income Level*
MR: *Mentally Retarded*
OBRA: *Omnibus Budget Reconciliation Act (relevant year should follow)*
PHP: *Prepaid Health P/an*
PNA: *Persona/ Needs Allowance*
PRO: *Professional (or Peer) Review Organization*
QMB: *Qualified Medicare Beneficiary*
SHMO: Social *Health Maintenance Organization*
SMI: *Supplemental Medical insurance*
SNF: *Skilled Nursing Facility*
SSI: *Supplemental Security Income*
TPL: *Third Party Liability*
UR: *Utilization Review*
WIC: *Women, Infants and Children (Supplemental Food* **Program)**

LEGISLATIVE REFERENCES

Note: Policies adopted through legislation are indicated with a legislative bill and law number (e.g. SB 1411, Ch.102, 1988 Laws). Policies adopted through Medicaid agency regulations or state plan amendments are noted as such, have initials other than those listed below or do not have any number indicated.

AB: *Assembly Bill*
HB: *House Bill*
HCR: *House Concurrent Resolution*
HJR: *House Joint Resolution*
HR: *House Resolution*
LB: *Legislative Sill*
SB: *Senate Sill*
SCR: *Senate Concurrent Resolution*
SJR: *Senate Joint Resolution*
SR: *Senate Resolution*

STATE PROFILES

ALASKA

BENEFITS & COVERAGE

Prescription Drugs: Makes permanent the inclusion of the prescription drug benefit under the medical assistance program. (Coverage of prescription drugs was included on a temporary basis in 1988) Program was implemented 2/1/89. (HB 70, 1989 Laws, effective 8/24/89)

ELIGIBILITY

No Changes

REIMBURSEMENT

Chiropractors: Chiropractors will not be reimbursed under Medicaid this year owing to lack of funds (HB 100, 1989 Laws, effective 7/1/89)

Hospitals: Corrects an unanticipated error in hospital reimbursement methodology. (SB 166, Chapter 9, 1989 Laws, effective 6/28/89)

Rate-Setting Commission: The Governor ordered through Executive Order 72 that the Alaska free-standing Rate Setting Commission become an advisory board and that all further responsibility for rate setting activities would be transferred to Department of Health and Social Services. (Executive Order 72, effective 3/11/89)

ADMINISTRATION & MANAGEMENT

No Changes

OTHER MEDICAID RELATED STRATEGIES

No Changes

INDIGENT CARE & UNINSURED PROGRAMS

Public Assistance: Allows public assistance recipients who are financially responsible for maintaining a residence to continue receiving payments during periods of institutionalization that last less than 3 months. (HB 65, 1989 Laws, effective 8/24/89)

ALABAMA

BENEFITS & COVERAGE

No Changes

ELIGIBILITY

MCH: Allows pregnant women who have lost Medicaid benefits because of fraud, abuse or misuse to be reinstated on a restricted status for pregnancy-related services only; each case will be reconsidered by utilization review committee within 60 days after the birth of the child. (SB 124, Act 530, 1989 Laws, effective 5/4/89)

REIMBURSEMENT:

No Changes

ADMINISTRATION & MANAGEMENT

Eyeglasses/Competitive Bidding: Authorizes one contractor, who will be selected through a competitive bidding process, to provide prescription eyewear for no more than three years. (SB 191, Act 89-657, 1989 Laws, effective 5/11/89)

Nursing Homes/Compliance: Expands authority of Medicaid agency to enforce compliance of state licensed ICFs and SNFs as mandated in OBRA '87. (SB 547, Act 641, Laws 1989, effective 5/9/89)

OTHER MEDICAID RELATED STRATEGIES

No Changes

INDIGENT CARE & UNINSURED PROGRAMS

Trust Fund: Two companion bills: SB 308 amends Alabama constitution to create a "Penny Trust Fund" to which citizens may make voluntary donations. Fifty percent of proceeds will be dedicated to public health programs and 50% shall be dedicated to public schools. (SB 308, Act 462, 1989 Laws, effective 5/4/89). SB 309 allocates revenue from Penny Trust Fund as follows: Public health funds will be divided

equally between programs to reduce infant mortality and/or improve child health and indigent health programs. The revenue for public schools (50% of the fund) shall be deposited in the Special Educational Trust Fund and will be equally divided among the following programs: (1) prevention of substance abuse; (2) children's immunizations; (3) programs to promote health and disease prevention; and (4) student nutrition and nutritional education programs. (SB 309, Act 667, 1989 Laws, effective 5/1//89)

ARKANSAS

BENEFITS & COVERAGE

MCH/DSH: Amends coverage and reimbursement for inpatient hospital services for infants under one year in disproportionate share hospitals. (effective 7/1/89)

Optional Services: The state has added by regulation coverage and reimbursement provisions for the following services: (1) portable X-ray services (effective 1 /1/89); (2) physical therapy, occupational therapy and speech pathology (effective 8/1/89); (3) licensed psychologists services (effective 9/1/89); and (4) rehabilitative services for persons with mental illnesses (effective 2/1/89).

Prescription Drugs: Increases by regulation prescription drug benefits from 4 to 6 prescriptions per month per recipient. (effective 4/1/89)

ELIGIBILITY

MCH: Raised income eligibility level for pregnant women and infants to 100% of poverty as allowed under SOBRA (effective 4/1/89). Disregards income changes of a pregnant women certified in any Medicaid category and extends eligibility through the end of the month in which the 60th day postpartum falls (effective 7/1/89). Raises upper age limit to 7 for SOBRA children under 100% of poverty (effective 10/1/89).

OMB: Implemented QMB coverage at 85% of poverty in accordance with federal law. (effective 1/1/89)

Spousal Impoverishment: Implemented spousal impoverishment requirements mandated under the Medicare Catastrophic Coverage Act of 1988. (effective 101/89)

Transfer of Assets: Implemented Medicaid coverage only for institutionalized residents who have transferred assets. (effective 10/1/89)

REIMBURSEMENT

Hospitals:

Rural: Established a separate class group for reimbursement to rural acute care hospitals with 99 or less licensed beds or whose average daily census was 50 patients

or less during the preceding year. (effective 1/1/89). Established an upper limit of $438 Per day for rural acute care hospitals. (effective 7/1/89)

Teaching: Established a separate class group for reimbursement to Arkansas State Operated Teaching Hospitals. (effective 7/1/89)

Nursing Homes:

Methodology: Requested the State Department of Human Services to continue studying reimbursement methodologies, ways to modify methods, to better inform public of quality of care in any given nursing home facility. (Senate Concurrent Resolution, approved 1/30/89.)

Rates: Increased the nursing home reimbursement rate 15% over the previous per idem rates. (effective 7/1/89)

Staffing: Requests the Department of Human Services to continue the study of nursing home reimbursement as it relates to public evaluation of the quality of care provided in nursing facilities. (SCR, adopted 1989)

Optional Services: See "Benefits & Coverage"

ADMINISTRATION & MANAGEMENT

Alzheimer's: Establishes a state certification program for wings, units or rooms within a facility for specialized programs for Dementia, Alzheimer's Disease and related conditions; does not apply to hospital swing beds. (SB 88, Act 485, 1989 Laws, effective 7/3/89)

Providers/Audits: Requires all corporations eligible to receive payments of $25,000 or more for services provided under Medicaid to provide an annual financial audit within 120 days of the close of the corporation's fiscal year. (law previously only required audits of non-profits receiving such payments) (SB 488, Act 942, 1989 Laws, effective 7/1/89)

MCH: Eliminated AFDC standard filing unit from consideration in AFDC-related Medicaid cases (U.S. 8th Circuit Court of Appeals decision, Olson vs. Norman and HCFA policy interpretation, effective 10/1/89)

Nursing Homes/LTC:

Licensure:

1. Statement of disclosure required by long-term care facility to residents under this law must be submitted when renewing license and must state if the facility has ever

been convicted of Medicare or Medicaid fraud. (SB 18 1, Chapter 10-229, 1989 Laws, effective 7/3/89)

2. Establishes criteria for licensure for new or expanded long-term care facilities. (SB 184, Act 665, 1989 Laws, effective 7/3/89)

Patient Rights:

1. Allows residents entering a long-term care facility a fourteen day period to rescind any contractual obligation entered into with a full refund of any moneys transferred to the facility. (SB 179, Act **663,** 1989 Laws, effective 7/3/89).

2. Prohibits taking photographs of medicaid recipient in LTC facility without written consent. (SB 31, Act 33, 1989 Laws, effective 7/3/89)

Preadmission Screening: Implemented preadmission medical necessity determination process for Medicaid clients applying for nursing home services. (effective 1/1/89)

OTHER MEDICAID RELATED STRATEGIES

Nursing Homes/Staffing: Established new LPN and Nursing Assistant staffing standards requiring two additional LPNs (effective 1/1/90) and three Nursing Assistants (effective 10/89) daily for an average size facility.

INDIGENT CARE & UNINSURED PROGRAMS

Medically Indigent Program: Reenacts legislation authorizing the establishment of an indigent medical care program (HB 1890, Act 821, Laws 1989, effective 7/3/89).

Uninsured Children's Program: Establishes program for provision of services to children whose gross family income does not exceed 185% and who are not covered by Medicaid or other public assistance programs (HB 1508, Act 471, Laws 1989, effective 7/1/90)

ARIZONA

BENEFITS & COVERAGE

Bone Marrow Transplants: Adds autologous bone marrow transplants as an AHCCCS covered service if federal financial participation is available. (SB 1348, Chapter 293, 1989 Laws, effective 9/30/89)

ELIGIBILITY

LTC for DD: Denies Arizona Long-Term Care System (ALTCS) eligibility to developmentally disabled clients who voluntarily refuse to cooperate in the eligibility process. (SB 1348, Chapter 293, 1989 Laws, effective 9/30/89)

MCH: Expands income eligibility for services to pregnant women and infants under AHCCCS to those with family incomes are below 130% (up from 100%) of the federal poverty level (FPL). (SB 1348, Chapter 293, 1989 Laws, effective 7/1/90)

QMB: (SB 1151, Chapter 5, 1989 Laws, effective 4/3/89)

QMB-Only: Requires AHCCCS administration to determine a person's eligibility as a Qualified Medicare Beneficiary (QMB)-only (meaning that the individual meets QMB requirements but is not otherwise categorically eligible). Requires the counties to screen eligible MN/MI's to determine whether a person may be eligible for QMB coverage. Potential applicants will be referred to the AHCCCS administration for final eligibility determination. Stipulates that applicants who refuse to cooperate in the eligibility determination process will not be eligible for QMB coverage. Requires the applicant to sign a form explaining loss of benefits due to refusal to cooperate. Allows AHCCCS to pay premiums, co-insurance and deductibles of eligible QMB-only recipients in a fee-for service arrangement or with a provider. The director may contract with a Medicare risk contractor. A person who is currently enrolled in AHCCCS as a MN/MI and is determined to be eligible for QMB-only coverage, is entitled to receive Medicare benefits.

Dual Eligibles: Requires the Department of Economic Security (DES) to assist the AHCCCS Administration in screening all non-SSI categorically eligible applicants who are entitled to Medicare benefits to determine an applicant's eligibility for QMB coverage. Requires AHCCCS to enroll and to notify individuals of their dual eligibility status. A person who is determined to be dually eligible is entitled to both Medicaid and Medicare benefits beginning 7/1/89. Requires that payment of deductibles and coinsurance amounts for services provided to dual eligibles be limited to services that are provided by or referred by a primary physician. The inability to

obtain documentation does not mean a refusal to cooperate on the part of the applicant. If the policy is not implemented, the director may enroll a dually eligible member with an available AHCCCS provider or program contractor located near a member's residence.

Snousal Impoverishment: Conforms ALTCS treatment of income and resources of an institutionalized spouse with federal law. Sets minimum resource allowance of community spouse or family of a nursing home resident at $12,000 to be adjusted annually based on the CPI. (SB 1348, Chapter 293, 1989 Laws, effective 9/30/89)

REIMBURSEMENT

Hospitals/Adjusted Bill Charges (ABC): Maintains reimbursement levels that were in effect prior to October 1, 1989. Reimbursement may not exceed the following levels: (1) 90% of the adjusted bill charges (ABC) for bills paid with 25 days of the date the bill is received; (2) for bills paid between 25 and 46 days, 95% of the ABC; and 3) 105% ABC plus interest for bills paid after 45 days. (SB 1007, (Technical Correction) Chapter 292, 1989 Laws, effective 9/15/89)

Providers/Capitated Payments: As of 10/1/89, allows prepaid capitated providers to require subcontracting providers or nonproviders to be paid for covered services, other than hospital services, according to the capped fee-for-service schedule adopted by AHCCCS or at lower rates negotiated by the prepaid capitated provider. (SB 1348, Chapter 293, 1989 Laws, effective 9/30/89)

A House amendment not included in the final bill deletes requirement that, after 7/1/89, AHCCCS increase capitation payments to health plans annually based on the average increase experienced by HMOs on a county-by-county basis during the preceding year.

ADMINISTRATION & MANAGEMENT

Adult Foster Care: Defines adult foster care services and clarifies that the maximum number of adults in a home may not exceed four. (SB 1348, Chapter 293, 1989 Laws, effective 9/30/89)

Claims and Recovery: Allows prepaid capitated providers to conduct postpayment review of claims and to recoup monies erroneously paid. Requires AHCCCS to recover federal sanctions from the DES due to inaccurate eligibility determination. (SB 1348, Chapter 293, 1989 Laws, effective 9/30/89)

ARIZONA CONTINUED

Cost Containment: Converts populations who currently receive health care under AHCCCS through state funding to federally funded programs. Applicants must apply for SOBRA eligibility concurrently with MN/MI application. (SB 1151, Chapter 5, 1989 Laws, effective 4/3/89)

County Contributions to AHCCCS: Requires county contributions to be made to the State Treasurer by the fifth day of the month , rather than the fifteenth day, as of October 1, 1989. (SB 1348, Chapter 293, 1989 Laws, effective 9/30/89)

ELIC, MN/MI & SOBRA: Requires counties to take concurrent applications for ELIC, MN/MI and SOBRA programs. Requires DES to complete SOBRA determinations within 10 working days for routine applications for MN/MI or ELIC assistance. Counties are authorized to complete MN/MI and ELIC determinations if the DES has not completed them within the 10 days. Counties are authorized to complete an MN/MI and ELIC determination for hospitalized applicants prior to referral of SOBRA applications to DES. Requires a county to reimburse AHCCCS for health care costs incurred for a person certified for MN/MI or the children's health program by the county, but who in fact is eligible for SOBRA. Specifies that the counties shall receive federal funds to cover costs incurred in completing the application for a person's SOBRA eligibility. SOBRA eligible applicants will continue to count as a member of the household in determining the household's eligibility for MN/MI benefits. Stipulates that applicants who refuse to cooperate in the eligibility determination process will not be eligible for AHCCCS. Requires the applicant to sign a form explaining loss of benefits due to refusal to cooperate. The inability to obtain documentation does not mean a refusal to cooperate on the part of the applicant. (SB 1151, Chapter 5, 1989 Laws, effective 4/3/89)

Hospitals: (SB 1348, Chapter 293, 1989 Laws, effective 9/30/89)

ABCs: Establishes reporting requirement for ABCs for hospitals to the Department of Health Services and AHCCCS. Allows the director of DHS to waive or impose civil penalties for violations for ABC provisions, not to exceed $300 per day per violation. Enhanced reporting requirements have sunset date of 10/1/93.

Emergency Services: Deletes requirement that determination of need (DON) for emergency services or for patient transfers be made by a special panel of physicians. Requires director to submit a monthly report to the President of the Senate and the Speaker of the House containing: (1) actual year to date expenditures and projected annual expenditures; (2) actual member months by rate code; and (3) actual case load, distinguishing between CNs, MN/MIs and QMBs. Report must be submitted by the 25th day of the following month.

Indian Health: Establishes a 43-member advisory council on Indian Health Care within AHCCCS. The council will develop a health care delivery and financing system for American Indians, focusing on demonstration projects. The Council must

report to the Governor and Legislature by November 1 of each year. (SB 1348, Chapter 293, 1989 Laws, effective 9/30/89)

Loss of Benefits: Requires form which explains loss of benefits due to refusal to cooperate, to be signed by MN/MI, ELIC and QMB applicants. (SB 1151, Chapter 5, 1989 Laws, effective 4/3/89)

LTC: Establishes the Office of the State Long-Term Care Ombudsman under the Department of Economic Security and Aging and Adult Administration Program as required under the Older Americans Act (amended under P.L. 100-175). (HB 2421, Chapter 215, 1989 Laws, effective 9/15/89)

Nursing Homes:

Compliance/Sanctions: Amends remedies for violations of nursing home provisions such that when life or safety of patients may be immediately affected, the director of the department of health services may approve the transfer of selected patients out of the facility. Also authorizes the department to write rules regarding background investigations into applicants for nursing home licensure. (SB 1355, Chapter 255, 1989 Laws)

Nurse Aide Training: Brings state statutes into compliance with nurse aide training requirements under OBRA-87. (SB 1348, Chapter 293, 1989 Laws, effective 9/30/89)

Preadmission Screening: Establishes a Level I and Level II preadmission screening process for applicants to Medicaid certified nursing homes to identify those applicants who may be mentally ill/retarded as required under OBRA-87. (SB 1151, Chapter 5, 1989 Laws, effective 4/3/89)

Provider Contracts: Allows the director to award a capped fee-for-service contract without bid for health and medical services, other than hospital services, to a health care services organization if there is either an insufficient number of contracts awarded to prepaid capitated providers or inadequate member capacity. (SB 1151, Chapter 5, 1989 Laws, effective 4/3/89)

OTHER MEDICAID RELATED STRATEGIES

No Changes

INDIGENT CARE & UNINSURED PROGRAMS

Elinibilitv Determination for ELIC/MN/MI and SOBRA Programs: Requires the county to assist potential recipients with eligibility application and documentation process. Allows county to certify or recertify eligibility status if DES does not make

a determination within 10 working days. Requires county to maintain files of clients' applications and documentation; these files are subject to quality control review. If a county certifies a client as indigent who later turns out to be eligible for assistance under AHCCCS, the county must reimburse the state for expenses improperly incurred for services provided to that individual. (SB 1348, Chapter 293, 1989 Laws, effective 9/30/89)

CALIFORNIA

BENEFITS & COVERAGE

Alzheimer's: Authorizes Medi-Cal to cover identification bracelets for victims of Alzheimer's Disease as a benefit, subject to the availability of federal financial participation. (SB 797, Chapter 1082, 1989 Laws, effective 1/90)

CBS/Home Health for Children: Stipulates that, when deemed medically appropriate by the state, in-home medical care and home and community-based services will be provided by a licensed home health care service agency to children with special needs in foster family homes. (SB 1466, Chapter 1175, 1989 Laws, effective 1/90)

Prescription Drugs:

AIDS: Establishes a new drug program for persons with HIV infection. Will pay for AZT, aerosolized pentamidine and gangciclovir for persons with annual incomes of up to $30,000, and some subsidies for those above that level. (AB 2251, Chapter 1246, 1989 Laws, effective 1/90)

QMBs: Covers prescription drugs for QMBs, provided that Medicare recipients are offered the same drug coverage as categorically needy recipients. (SB 1413, Chapter 1430, 1989 Laws, effective 1/90)

Respite Care: Provides respiratory care as a covered service under Medi-Cal. (AB 224, Chapter 1433, 1989 Laws, effective 1/90)

ELIGIBILITY

Disabled: Continues Medi-Cal eligibility for conditions excluded from coverage by private insurers to disabled persons who are otherwise eligible for Medi-Cal, except for income due to employment. Applies only to individuals whose income does not exceed 200% of the maintenance level established by the state. Contingent on availability of federal matching funds. (SB 1468, Chapter 883, 1989 Laws, effective 1/90)

Spousal Impoverishment: Revises upward the income and resource rules for a person in the community whose spouse is in a nursing home and applying for Medicaid as part of the state's efforts to implement the MCCA of 1988. Sets community spouse resource limit at $60,000, the maximum allowed under federal law. (SB 1413, Chapter 1430, 1989 Laws, effective 1/90)

CALIFORNIA CONTINUED

Transition-to-Work: Extends Medi-Cal benefits for up to 12 months to persons who have lost their cash benefits due to earnings as required under the Family Support Act of 1988. (AB 894, Chapter 1016, 1989 Laws, effective 1/90)

REIMBURSEMENT

DRGs/Children's Hospitals: Makes permanent the pediatric diagnostic related group system for reimbursing children's hospitals. (SB 471, Chapter 325, 1989 Laws, effective 9/89)

DSH: Establishes a "Disproportionate Share and Emergency Services Fund" to provide additional reimbursement to hospitals participating in the Medi-Cal program who serve a disproportionate share of low-income patients. (SB 1255, Chapter 996, 1989 Laws, effective 1/90)

MCH: Eliminates the differential in payment between Caesarean section and non-Caesarian section services. (AB 708, Chapter 348, 1989 Laws, effective 1/90)

Medicare Buy-In: Incorporates provisions of the Medicare Catastrophic Coverage Act of 1988 into state law. Authorizes payment by Medi-Cal for premiums, deductibles and coinsurance for individuals eligible for Medicare with income below 200% of the poverty level. (SB 1413, Chapter 1430, 1989 Laws, effective 1/90)

Nursing Homes: Eliminates the distinction between a SNF and an ICF, calling each a "nursing facility". Requires the Department of Health Services (DHS) to draw up new regulations establishing payment rates for nursing facilities. (SB 1414, Chapter 731, 1989 Laws, effective 1/90)

Prescription (Experimental) Drugs: Medically necessary inpatient and outpatient services associated with the administration or treatment of investigational new drugs (IND) are now reimbursable under the Medi-Cal program. (AB 1625, Chapter 1193, 1989 Laws, effective 1/90)

ADMINISTRATION & MANAGEMENT

Case Management Tracking System: Requires the state to develop a system that would inform Medi-Cal providers whether a beneficiary is subject to receive case-management services for all non-emergency services. Once established, if the system fails to inform a provider that the beneficiary is subject to case management, the provider will be reimbursed for such services. (AB 210, Chapter 1433, 1989 Laws, effective 1/90)

Child Support: Amends existing law that requires that health insurance coverage to be maintained for children for whom a support order has been issued, if it is available at no cost or a nominal cost to a parent or the parents. The amendment would require such health insurance if it is available at no cost or a reasonable cost. (SB 1380, Chapter 804, 1989 Laws, effective 1/90)

Corrections: Revises current law to make buying or selling a Medi-Cal card, label or beneficiary identification number a public crime, punishable by up to one year in jail and a $5,000 fine. (AB 1915, Chapter 1267, 1989 Laws, effective 1/90)

Cost-Containment: Directs the DHS to study and enhance efforts to reduce the eligibility rate by 0.5% and to increase third party liability collections by 10%. Allows publishing changes in Medi-Cal regulations only after fiscal review and approval by Department of Finance. (SB 165, Chapter 93, 1989 Laws, effective 7/89)

MCH:

Case Workers: Allows counties to petition the state to out-station Medi-Cal eligibility workers at alternative sites (e.g., clinics) to facilitate the receipt and processing of applications for Medi-Cal eligibility for pregnant women. (SB 822, Chapter 1446, 1989 Laws, effective 1/90)

Eligibility Determination Process: Requires the DHS to report to the legislature on the feasibility of implementing a common eligibility procedure and uniform eligibility standard for programs delivering services to pregnant women, women with infants and young children, and programs for children and adolescents. The report must cover programs which currently provide nutritional supplements, immunizations, health education and other services as decided by the department. The report must include the following: (1) a description of federal statues, regulations, and guidelines concerning eligibility and options for exemptions from the requirements; (2) a description of state statutes and regulations requiring amendment in order to develop a single uniform eligibility standard and determination procedure; and (3) changes in administrative structures at the state and local level that would be necessary to improve coordination of services to these populations. Appropriates $155,000 for the study. (AB 1695, Chapter 1198, 1989 Laws, effective 1/90)

Nursing Homes/Licensure:

1. Authorizes the state to extend provisional licensure for a nursing home when providing a change of ownership to instituting a receivership of the facility. (AB 931, Chapter 811, 1989 Laws)

2. Requires applicants seeking a nursing home license to have financial resources sufficient to operate the facility for 45 days. Also requires disclosure of those persons and entities **having an ownership interest of 5% or more.** (SB **1525, Chapter 885, 1989** Laws, effective 1/90)

CALIFORNIA CONTINUED

Physician Education Program: Provides funds for an educational and technical assistance program to assist physicians in gaining knowledge in: (1) Medi-Cal reimbursement and billing and (2) Medi-Cal fiscal intermediary procedure to assist physicians in receiving Medi-Cal reimbursement. (SB 165, Chapter 93, 1989 Laws, effective 7/89)

Prescription Drugs:

Formulary Approval: Allows a drug manufacturer to submit one of the following in order to have a drug added to the state formulary in lieu of the FDA Summary Basis of Approval: (1) FDA approval or approval letter for the drug and FDA-approved labeling; or (2) FDA's medical officers' and pharmacologists' reviews, and the FDA's approved labeling. (SB 492, Chapter 689, 1989 Laws, effective 1/90)

Non-Formulary Authorization: Establishes special treatment authorization request process that allows physicians to prescribe a single-source drug under certain circumstances when the single-source drug has been removed from the Medi-Cal formulary. (SB 165, Chapter 93, 1989 Laws, effective 7/89)

Recovery:

Estate: Requires the DHS to waive its claim for Medi-Cal services against the estate of a decedent or the recipient of property of that decedent, if enforcement of the claim would result in substantial hardship to other dependents of the individual against whose estate the claim exists. (SB 177, Chapter 1201, 1989 Laws, effective 1/90)

TPL: Requires Medi-Cal to recover third party liability for the cost of targeted case management services. (AB 1657, Chapter 532, 1989 Laws, effective 1/90)

OTHER MEDICAID RELATED STRATEGIES

AIDS

Access Study: Requests the California Medical Assistance Commission (CMAC) to study the problems of the distribution of health care for AIDS patients in hospitals in major metropolitan areas, and requests recommendations on ways to increase access for these persons. (SB 174, Chapter 1406, 1989 Laws, effective 1/90)

Care Coordination Feasibility Study: Directs the DHS to conduct a feasibility study on the coordination of various levels of health care within one program in a city or county to serve persons with HIV infections, AIDS related complex, and AIDS. DHS will develop a report in conjunction with the Office of Statewide Health Planning and Development and submit it to the legislature by 7/1/90. (SB 844, Chapter 793, 1989 Laws, effective 1/90)

Cost Study: Directs DHS to contract for a two-year prospective study of the medical costs of AIDS. The study will compare inpatient and outpatient services, physician services, and community support services. It will also include cost factors in the review of inpatient costs which may not be apparent in the analysis of charges, such as private rooms and social work. An interim report is due with 6 months of the receipt of funding; the final report is due within 2-years of funding. (SB 844, Chapter 793, 1989 Laws, effective 1/90)

HIV/Drug-Exposed Children: Requires the DHS to report to the legislature on the various federal waivers for HIV and drug exposed foster children. (SB 1466, Chapter 1175, 1989 Laws, effective 1/90)

HIV Intervention/LTC: Establishes a program to provide early intervention and long-term care services to persons infected with HIV, including education and the coordination of services. (AB 160, Chapter 949, 1989 Laws, effective 1/90)

Emolover-Soonsored Health Benefits/Task Force: Establishes statewide statutory framework for mandating that employers with 5 or more workers offer a minimum package of health insurance benefits. Benefits include inpatient and outpatient hospital care, physician services, maternity care, and mental health services not attributable to substance abuse. Creates a task force to study feasibility of mandating employer-based benefits. The plan is scheduled to go into effect in 1992, subject to the recommendations of the task force. (AB 350, Chapter 829, 1989 Laws, effective 1/92)

Home Health & Hospice Premium Payments: Directs the Medi-Cal program to pay private insurance premiums for participants in the states pilot projects assessing the cost-effectiveness of home health, attendant and hospice care. Such premiums will only be paid where they are shown to be cost-effective. (AB 532, Chapter 1055, 1989 Laws, effective 1/90)

LTC Pilot Project: Authorizes the Department of Health to establish 5 demonstration projects for the purpose of developing risk-based capitated long-term care pilot programs similar to the On Lok Health Services project, (AB 601, Chapter 821, 1989 Laws, effective 1/90)

Managed Care: Extends Santa Barbara managed care pilot project until 6/30/93. The program was scheduled to be terminated in 1990. (SB 671, Chapter 224, 1989 Laws, effective 1/90)

CALIFORNIA CONTINUED

INDIGENT CARE & UNINSURED PROGRAMS

MCH/Hospitals: Requires the CMAC, which negotiates contracts with hospitals for services under Medi-Cal, to take into consideration during negotiations hospitals that provide additional obstetrical beds, contract with one or more comprehensive perinatal providers, permit certified nurse midwives to admit patients, or expand overall obstetrical services in the hospital. (AB 52, Chapter 8, 1989 Laws, effective 4/89).

"Sin Tax" Programs: Establishes several new programs and expands Medi-Cal to assist the indigent. Creates programs to: (1) fund primary care clinics for providing services to individuals at or below 200% of the federal poverty level; (2) expand perinatal services to pregnant women between 185% and 200% of poverty; (3) provide funding to compensate hospitals for uncompensated care; (4) provide funds to maintain rural health services for persons who are unable to pay; (5) establish the California Health Care for Indigent programs that will provide counties with funds to pay hospitals, physicians and other entities providing services to the indigent; and (6) provide additional funds to children's hospitals based on the relative amount of uncompensated care they each provide. Funding for all of these activities will come from the state's "Cigarette and Tobacco Products Surtax Fund". (AB 75, Chapter 1331, 1989 Laws, effective 9/1)

Uninsurables: Establishes the "California Major Medical Insurance Program", a health coverage program to provide health insurance to state residents who are not otherwise able to obtain adequate health insurance. An individual must have been rejected by at least one private health plan to become eligible. The state will contract with private plans to provide the coverage and will finance the program through the state's cigarette tax. (AB 60, Chapter 1168, 1989 Laws, effective 1/90)

COLORADO

BENEFITS & COVERAGE

No changes

ELIGIBILITY

CBS/Home Health/Disabled Children: Creates program to provide less costly community-based or home health services to disabled children who are 18 years of age or under and who (1) have medical needs which would require or place them at risk of being institutionalized; (2) are currently institutionalized under Medicaid; (3) have incomes at or below 300% of the income benefit level for SSI; and (4) are not eligible for other long-term care waiver programs. Requires program review every six months and evaluation report including issues of cost-effectiveness and quality of care to the general assembly by 1/1/90. (HB 1066, 1989 Laws, effective 6/1/89).

Japanese Americans: Prohibits inclusion of income received from reparation payments under Civil Liberties Act (P.L. 100-383) as countable resources for determining income eligibility under Medicaid and state public assistance programs. (HB 1263, 1989 Laws, effective 4/26/89)

MCH: Creates "Baby Care" program to expand prenatal care to pregnant women and infants: (1) Income eligibility is phased in--75% federal poverty level in 1990, 100% by 1991 and 150% by 1992; (2) Adds presumptive eligibility; (3) creates advisory committee to assist with implementation and evaluation of program. (HB 1089, 1989 New Laws, effective 6/6/89)

QMB: Expands eligibility to include medicare eligibles who fall within the income eligibility standards set forth in the Medicare Catastrophic Coverage Act (MCCA) of 1988 -- 85% of the federal poverty level in 1989, 90% in 1990. (HB 1005, 1989 Laws, effective 6/5/89).

Spousal Impoverishment: Increases minimum monthly maintenance needs allowance to 122% of the federal poverty level by 9/30/89, to 133% by 1990, and to 150% by 1991 as required under the MCCA; Allows for increased shelter and utilities expenses that exceed 30% of the minimum monthly needs allowance, not to exceed a total of $1500; To determine total community assets, community resources will be divided 50/50 beginning at time of continuous period of institutionalization, allowing the community spouse to retain the first $12,000 up to $60,000 as the community spouse resource allowance; income allowance levels will be indexed for urban recipients. (HB 1004, 1989 Laws, effective 9/30/89)

COLORADO CONTINUED

REIMBURSEMENT

Home Health/Personal Care Services: Maximum reimbursement for personal care services provided by a family member except a spouse may not exceed $5000 per family per year or 50% of the maximum amount of authorized expenditures under Medicaid. As mandated by federal law, personal care services provided by a spouse are not reimbursable. (HB 1009, Title 26, Article 4, Section 109.5, 1989 Laws, effective 4/4/89)

Nursing Homes/Personal Needs Allowance: Personal needs payments to recipients admitted to nursing home is increased from $29 to $34. (HB 1004, 1989 Laws, effective 9/30/89)

ADMINISTRATION & MANAGEMENT

Nursing Homes:

Compliance/Sanctions: Allows department to use intermediate sanctions for nursing home non-compliance under Medicaid and Medicare as allowed under OBRA '87. Develops remedies to be assessed against Medicaid-approved nursing homes in violation of standards set by federal nursing home reforms. Sets up a nursing home penalty cash fund and grants additional authority to the department of social services. Funds may be expended to protect nursing home residents. Civil money penalties may range from $100.00 up to $10,000.00. Legal rates of interest for each day a facility violates federal regulations may apply. Establishes criteria for assessing the amount of penalty based on time, frequency, intentions, effects on patients, accuracy of facility's records and numbers of additional violations. All functions specified in this statute are scheduled to terminate on July 1, 1993, pending re-evaluation by the general assembly. Appropriates about $35,000 each to departments of law, health and social services for the implementation of these provisions. (SB 5-X, 1989 Laws, effective 7/11/89)

Nurse Aides Training: Sets up training, education and certification program of nurse aides in accordance with federal law. Pertains to nurse aides employed in Medicare/-Medicaid approved nursing facilities, distinct part nursing facilities and Medicare certified home health agencies. The practice of nurse aide follows federal language. Allows for application by competency evaluation and by endorsement. Applicants must stipulate that they have not committed any act or omission that would be grounds for discipline or denial of certification. Areas to be assessed include those identified in federal language. The following topics should be included in the curriculum: communication and interpersonal skills, infection control, safety and emergency procedures, promoting residents and patients independence, respecting residents and patient rights. Nurse aide training programs must be inspected once during the first year and every two years thereafter by the board. The board must not require nurse aide training requirements that substantially exceed the requirements

established under OBRA-87. Renewal is biennial. The board may designate a five-member advisory board to assist in the performance of these duties. Stipulates grounds for discipline that include substance abuse. All applicants for certification as a nurse aide will be deemed to have given consent to undergo a physical or mental examination at any time the board requests it. Such requests must be in writing and include the basis for this examination. Allows for disciplinary proceedings and hearings to be handled through the department of regulatory agencies. Employers are required to report any disciplinary action taken against a nurse aide or any resignation in lieu of a disciplinary action for conduct. Persons have within the first four months of employment at a medical facility to become certified. (HB 1001, 1989 Laws, effective 7/7/89)

Appropriates $1.5 million and 13.0 FTEs (full-time equivalent) to the Department of Regulatory Agencies to implement this act. Money may come from federal funds and fees collected pursuant to nurse aide certification. Also, appropriates up to $604,000 to the Department of Social Services for implementation of this act. The Department of Law will receive $39,780 and 0.6 FTE. The department of administration, in order to conduct hearings, will be funded for 0.3 FTE.

Patient Rights: Assures patient's rights for individuals residing in nursing homes as required under OBRA '87. (HB 1010, 1989 Laws, effective 4/4/89)

Pharmaceutical contracts: Excludes HMOs or prepaid health plans that enroll less than 40% of all resident Medicaid recipients in counties with more than 1000 Medicaid recipients from contracting with state qualified pharmaceutical vendors. (SB 58, 1989 Laws, effective 10/1/89)

Recovery: Requires the Department to report to the Department of Revenue the name, social security number, amount owed of any recipient who is obligated to the state for overpayment. Authorizes district attorney to obtain from Department any information that will lead to location of individuals who have fraudulently obtained medical assistance under Medicaid. Eliminates county share (25%) and costs incurred from obtaining recovered funds. (SB 153, 1989 Laws, effective 6/7/89)

OTHER MEDICAID RELATED STRATEGIES

AIDS/Employer-Based Health Insurance: Establishes 2-year pilot program and feasibility study determine cost-effectiveness of state payments for employee health insurance premiums under COBRA for certain individuals with AIDS. (SB 1, Special Session, 1989 Laws, effective 7/1/90; repealed 7/1/92 unless continuation is authorized by general assembly)

COLORADO CONTINUED

Home Health/Waivers

AIDS: Requests federal waiver to provide home health care services to patients with AIDS and AIDS related health problems in lieu of hospital care (Section 301-306, effective 7/1/89).

Disabled Children: Requests Department to qualify for federal financial participation in the disabled children home care program, contingent on cost-effective of program described above. (HB 1066, 1989 Laws, effective 6/1/89).

INDIGENT CARE & UNINSURED PROGRAMS

No changes

CONNECTICUT

BENEFITS & COVERAGE

Home Health: Requires all individuals who wish to participate in either the Department of Income Maintenance's (DIM) preadmission screening and community-based services program or in the Department of Aging's promotion of independent living program to apply for Medicaid if the agency asks them to do so and to accept those benefits if they are determined to be eligible. (HB 7604, Public Act 89-296, Laws 1989, effective 7/1/89)

Prescription Drugs: Unless a licensed medical practitioner specifies a particular brand name for a prescription using the language "Brand Medically Necessary" either in writing or verbally, a pharmacist must substitute the generically equivalent drug product. (SB 722, Public Act 89-111, Laws 1989, effective 10/1/89)

ELIGIBILITY

Children: Allows the regional or local Board of Education to request permission from a parent or legal guardian to apply for Medicaid on the behalf of a child who has been identified by the Board as needing a special education program and who has been determined by the Board to be eligible for Medicaid. Allows Board to request payment by Medicaid for the provision of special educational services to Medicaid-eligible children. (SB 469, Public Act 89-315, Laws 1989, effective 7/1/89)

Spousal Impoverishment: Adopts federal standards for income protection and resource allocation as established under the Medicare Catastrophic Coverage Act (MCCA) of 1988. The maintenance needs allowance for the community spouse increases from 122% of federal poverty to 133% on 7/1/91 and to 150% on 7/1/92. Allowance may not exceed $1500 per month in 1989 except by court order or administrative hearing. This limit may increase by inflation rate in future years as measured by the CPI. (SB 728, Public Act 89-317, Laws 1989, effective 7/1/89)

Transfer of Assets: Conforms state law to federal requirements under the MCCA: (1) Narrows application of the transfer of assets law from all Medicaid applicants and recipients to institutionalized individuals only; (2) increases from 24 to 30 months the time period during which institutionalized Medicaid applicants and recipients are prohibited from making an assignment or transfer of property for less than fair market value; and (3) exempts certain type of Medicaid transfer from ineligibility penalties. (SB 728, Public Act 89-317, Laws 1989, effective 7/1/89)

CONNECTICUT CONTINUED

REIMBURSEMENT

Elderly: Eliminates state support for residents of municipally operated homes for the aged (of which there is one) (HB 7604, Public Act 89-296, Laws 1989, effective 7/1/89)

Hospitals: Limits the maximum amount the state can pay for services to indigent patients at acute care and chronic disease hospital outpatient clinics and emergency room to the charge these institutions set for the general public. Reimburses non-emergency visits to a hospital emergency room at the hospital's outpatient clinic services rate. (HB 7604, Public Act 89-296, 1989 Laws, effective 10/1/89)

Nursing Homes:

Mental Retardation: Limits the growth of Medicaid payments to nursing homes, certain chronic disease hospitals and residential facilities for the mentally retarded and increases the differential between the Medicaid and private-paying nursing home rates for two years. Reduces cost-efficiency adjustments; eliminates payment for personal laundry and certain interest expenses; reduces the impact of inflation on the rates; and imposes an overall percentage rate reduction. Separates rate-setting for rehabilitation centers that provide employment opportunities and day services from other services. Rates will be set through a uniform payment system. (HB 7605, Public Act 89-325, 1989 Laws, effective 7/1/89)

Temporary Nurses: Establishes rate controls for temporary nursing pools for the two years that nursing home reductions are in effect. Requires nursing pools to register annually with the Department of Health Services and have their rates set for two years by the Commission on Hospitals and Health care (CHHC). During the first year the rates must not be more than the pool's actual costs as of 6/15/89 for compensation, "regulatory requirements" (not defined) plus an additional amount for overhead and profit. In the second year the rate may be adjusted for inflation. Rates are not regulated after two years. Act excludes both licensed institutions that operate their own nursing pool without a fee and individuals working on a temporary basis. (HB 7605, Public Act 89-325, 1989 Laws, effective 7/1/89)

Oxygen Products: Authorizes Medicaid to pay for oxygen products and services which are determined to be medically necessary according to Medicare criteria. Payment for oxygen administered through oxygen concentrators in convalescent, chronic and nursing homes are included in the per diem reimbursement rate. Alternative oxygen products and services in nursing homes may be reimbursed through Medicaid if they are substantiated as medically necessary. (HB 7604, Public Act 89-296, Laws 1989, effective 7/1/89)

Prescription Drugs: Sets reimbursement rate at federal level established by HCFA; if HCFA has not established a rate for a particular drug, the DIM must set and periodically revise an estimated acquisition cost in accordance with federal regulations. Requires commissioner to establish a professional fee paid to pharmacies

dispensing drugs to Medicaid recipients. (HB 7604, Public Act 89-296, Laws 1989, effective 7/1/89)

Rate Freezes: Continues current state payment rates for specified periods of time for the following services: (1) services other than treatments and employment provided by rehabilitation facilities and regional educational service centers; and (2) services provided to Medicaid recipients by home health care and homemaker-home health agencies, as well as community health centers and free-standing medical clinics. (HB 7605, Public Act 89-325, 1989 Laws, effective 7/1/89)

ADMINISTRATION & MANAGEMENT

MMIS: Requires development of information system to track (1) client and fiscal data on programs providing services (not limited) to pregnant women and children; (2) preadmission screening and nursing home reforms mandated by OBRA '87; (3) savings attributed to the Medicare Catastrophic Coverage Act of 1988; (4) Job Opportunities and Basic Skills Training program; (5) special shelter cost payments for AFDC, GA, and needy student program recipients; and (6) economic indicators, and rate and volume measures useful in projecting public assistance expenditures. Report must be submitted monthly to the Appropriations Committee beginning 9/1/89. (HB 7604, Public Act 89-296, Laws 1989, effective 10/1/89)

Nursing Homes:

Compliance/Sanctions: Allows DIM to take intermediary measures for noncompliance of SNFs and ICFs that participate in Medicaid as allowed under OBRA 1987. (HB 7228, Public Act 89-348, effective 6/30/89)

Facility Expansion: Allows nursing homes participating in both Medicaid and Medicare to expand once without obtaining approvals from CHHC. The expansion is limited to 10 additional beds and the total capital cost may not exceed $30,000 per bed, adjusted annually for inflation. (HB 7605, Public Act 89-325, 1989 Laws, effective 7/1/89)

Medicaid Participation: Allows nursing facilities to drop out of Medicaid program or decrease their Medicaid services without prior CHHC approval. If a home terminates its Medicaid agreement, it must transfer patients to participating facilities within 30 days; a limited extension may be granted by the DIM commissioner. The facility is responsible for any loss of federal reimbursement due to termination. (HB 7605, Public Act 89-325, 1989 Laws, effective 7/1/89)

Medicare Participation: Previous law required nursing homes to participate in Medicare to the extent that they participated in Medicaid. Under this act nursing homes may seek permission from DIM commissioner to have smaller proportion of facility certified for Medicare if at least part of the facility is Medicare-certified and

large enough to assure access to all Medicare recipients who might reasonably be expected to apply for admission or return to the home. Exempts facilities which participated in Medicaid but not Medicare on 5/1/89. (HB 7605, Public Act 89-325, 1989 Laws, effective 7/1/89)

Nurse Aide Training: Requires that persons to be hired as nurse aides tell of any criminal background or conviction. Failure to do so is subject to disciplinary action. A civil penalty of up to $100.00 may also be imposed. Applicants must sign an application form which includes questions about any criminal convictions. False statements regarding prior criminal convictions or disciplinary actions may constitute a Class A misdemeanor. Additional provisions pertaining to nursing home enforcement activities are included. (HB 7239, Public Act 89-350, 1989 Laws)

Patient Rights: Establishes patient's bill of rights for patients and residents of both levels of nursing homes, chronic disease hospitals, and boarding homes. Provides 13 new rights and expands existing rights. (HB 7228, Public Act 89-348, effective 6/30/89)

Patient Transfer or Discharge: (HB 7228,Public Act 89-348, effective 6/30/89)

1. Nursing homes: Slightly alters reasons for transferring or discharging patient from nursing facility to allow a transfer or discharge if patient does not need the home's level of care because the patient's health has improved; makes changes in the required 30 days notice of transfer/discharge to include voluntary transfers or discharges (prior law applied only to involuntary transfer or discharge). Nursing home is responsible for patient placement; establishes appeals process.

2. Boarding homes: Prohibits transfer or discharge of boarding home resident unless (1) it is done for the resident's welfare; (2) the resident's health has significantly improved; (3) the health or safety of the resident is in danger; (4) the resident has failed to pay; or (5) the home closes. Appeals process for boarding home residents is established.

3. Chronic disease hospitals: Prohibits patient transfer or discharge unless (1) it is documented for medical reasons or (2) the resident who is a self-pay patient is 15 days in arrears. Involuntary transfers or discharges require written notice to the resident and any legal guardian or conservator 30 days in advance if discharge plan has been prepared by the hospital's medical director.

Preadmission Screening: Requires preadmission screening for mentally retarded patients regardless of whether or not the person is on Medicaid. Nursing homes that admit such as patient who has not been screened will not be paid. (HB 7228, Public Act 89-348, effective 6/30/89)

Prescription Drugs: Requires DIM commissioner to (1) study reasonableness of state's payments for Medicaid drugs, including a generic incentive dispensing fee; (2) review prescription drug utilization by therapeutic category under Medicaid; (3) outline problems in administering the Medicaid prescription drug program, suggest solutions and make recommendations for system improvements; and (4) study feasibility of implementing limited high-volume drug formulary and pharmaceutical rebate programs--report due 2/15/90. Creates a lo-member advisory panel with which the commissioner must consult on these studies. (HB 7604, Public Act 89-296, Laws 1989, effective 7/1/89)

OTHER MEDICAID RELATED STRATEGIES

AIDS Demonstration Project: Requires DIM to set rates for demonstration project providing skilled and intermediate nursing home care for people with AIDS or ARC. The demonstration project must be in the metropolitan area with the highest incidence of AIDS in the state and which has a facility specifically established, equipped, and staffed for the project. (HB 7605, Public Act 89-325, 1989 Laws, effective 7/1/89)

LTC Pilot Project: Establishes six-year pilot program, "Connecticut Partnership for Long-Term Care", under which individuals may purchase private long-term care insurance that pays for nursing home and home care services and allows individuals to protect some of their assets if they eventually need Medicaid assistance. Individuals may purchase insurance in an amount commensurate with assets; people who buy or renew the precertified policy during the pilot period (1/1/90 through 12/31/94) receive asset protection for life. DIM will determine when insurance payments can start as well as Medicaid eligibility for participating individuals. The Insurance Department will precertify the policies; the Department on Aging will provide public information and consumer education; and the Office of Policy and Management is responsible for program coordination, evaluation and reporting. Initiation of project depends on the federal government allowing the state to change its Medicaid plan to permit this protection or approving the pilot program through some other means, such as legislation. (HB 7608, Public Act 89-352, 1989 Laws, effective 7/1/89)

Reimbursement Task Force: Establishes task force to study state rates for medical services to centers affiliated with the Easter Seal Society of Connecticut, rehabilitation centers, community health centers, residential facilities, homemakers-home health aid agencies, and other agencies providing similar services. Task force will (1) consider methods for establishing a new payment methodology to control costs; (2) evaluate possibilities for long term savings; and (3) recommend indexing procedures for this system. DIM commissioner must submit a final report with recommendations to the Human Services and Appropriations committees by 1/1/90. (HB 7605, Public Act 89-325, 1989 Laws, effective 7/1/89)

CONNECTICUT CONTINUED

INDIGENT CARE & UNINSURED PROGRAMS

General Assistance Programs:

COLAs: Makes permanent the annual cost of living adjustment (COLA) for General Assistance (GA) and State Supplement recipients. COLA is indexed to the consumer price index for urban consumers but it is limited to 5%. (HB 7604, Public Act 89-296, 1989 Laws, effective 7/1/89)

Income Protection: Codifies $250 protected asset provision currently in effect in state regulations; brings uniformity to provision of medically necessary services to individuals receiving general assistance; forces towns to comply with state regulations regarding fair hearing process for general assistance recipients and allows state to withhold GA funds to towns who don't comply. (SB 727, Public Act 89-239, 1989 Laws, effective 10/1/89)

Universal State Health Insurance/Commission: Establishes a "Blue Ribbon Commission on State Health Insurance" to (1) develop a comprehensive and universal state health insurance program and (2) consider various methods to fund uncompensated and undercompensated care in hospitals. Universal state health insurance (1) shall be available to all individuals in the state regardless of disability or pre-existing conditions who do not have employer-sponsored benefits or whose premiums under such a plan exceed the payments which would be required under the state plan; (2) shall be administered by the state and use a sliding fee scale based on household income and family size to set premiums; and (3) provide comprehensive coverage including inpatient, outpatient hospital and physician services, preventive and rehabilitation services and mental health services. Plan shall use cost-effective care models such as contracting and case management services and shall be financed by a combination of state, employer, and beneficiary contributions. Report is due to the joint standing committee of the general assembly by 2/1/90. (SB 341, Special Act 89-57, 1989 Laws, effective 7/3/89)

DISTRICT OF COLUMBIA

NO LAWS WERE PASSED IN THIS SESSION.

DELAWARE

BENEFITS & COVERAGE

MCH: Extends additional services to eligible pregnant women who are at risk of having a premature birth or a low birth-weight baby. These services include nursing, nutrition and social services. Requires prior authorization from the Medicaid Administrator. Women who elect to receive these services are given a choice of "Extended Services Providers"; services may be provided for the full term of the pregnancy and for 60 days after the baby's birth. (Implemented 5/1/89)

ELIGIBILITY

No Changes

REIMBURSEMENT

Nursing Homes/Rate-Setting:

Patient Index Reimbursement System Policy Statement: Providers of ICF and SNF care shall be reimbursed based on a patient index classification system composed of the following five prospectively determined rate components: (1) primary patient care; (2) secondary patient care; (3) support services; (4) administration; and (5) capital costs. The primary patient care component of the per diem rate is based on the nursing care costs related specifically to each patient's classification, In addition to assignment to one of the five basic classifications, patients may qualify for supplementary reimbursement for rehabilitative and/or psycho-social programs. The assignment to a classification for primary care reimbursement is based on the patient's characteristics and special service needs. Payment for the secondary, support, administrative, and capital costs comprise the base rate, and is unique to each facility. Provider costs are reported annually to Medicaid. These are used to establish per diem rates for each facility and the rate ceiling for the secondary, support and administrative cost centers in each provider peer group. This methodology was effective 10/1/88.

ADMINISTRATION & MANAGEMENT

Nursing Homes/Compliance: Allows state to deny payment to or impose a fine from 2% to 100% on nursing homes that provide care to Medicaid recipients and that are found to be in violation of federal regulations regarding standards of care. (SB 218, Chapter 79, 1989 Laws, effective 10/1/89)

DELAWARE CONTINUED

OTHER MEDICAID RELATED STRATEGIES

"Healthy Lifestyles" Health Insurance Certification Plan: In order for a health insurance plan to be certified by the state Insurance Commission it must provide the following: (1) economic incentives and disincentives substantial enough to encourage policy holders to modify their behavior; (2) significant economic disincentives and penalties to policyholders who falsely certify participation in the practice of health lifestyle behaviors that reduce health care claims; and (3) benefits for appropriate preventive health screenings and adult immunizations as recommended by the Delaware Department of Public Health. Delaware is the first state in the country to establish this type of Insurance Commissioner-certified health insurance program. To obtain an example of a plan which would meet with the Insurance Commissioner's approval or for more information, contact Marianne M. Chillas, Delaware Insurance Department, (302) 736-4251. (Regulation 60, "Certification and Standards for Health Plans or Policies, released 9/7/89)

LTC: Brings Delaware statues under compliance with the Older Americans Act Amendments of 1987 requiring states to have an Office of the Long-Term Care Ombudsman. This laws creates such an office and sets out the duties and responsibilities of the Ombudsman. (SB 195, Chapter 76, 1989 Laws, effective 7/10/89)

INDIGENT CARE & UNINSURED PROGRAMS

Access Study: Requests the Department of Health and Social Services to review strategies for increasing access to health insurance of the uninsured population including but not limited to (1) implementing tax credits and incentives; (2) expanding Medicaid coverage; (3) limiting malpractice liability; (4) developing uniform minimum benefits under current state insurance regulations; and (5) standardizing reimbursement levels for all payers based on an expanded version of the DRG system. (SCR 92, adopted 6/30/89)

FLORIDA

BENEFITS & COVERAGE

MCH/Teen Parents: Waives "return to school" requirement under the employment and training program for a postpartum teenage mother if a medical examiner finds complications preventing the mother's return to school. (HB 1245, Chapter 89-334, 1989 Laws, effective 10/1/90)

Medically Needy: Continues medically needy program under Medicaid. (SB 92, Chapter 89-92, 1989 Laws, effective 10/1/89.)

Transition-to-Work: Benefits under Medicaid will be extended for up to 12 months for an AFDC recipient whose earnings that result from returning to work cause the recipient to be ineligible for benefits. The Department of Health and Rehabilitation Services (DHRS) may use funds to pay for a family's premiums, deductibles, coinsurance and similar costs for health insurance, or other coverage offered by an employer of one of the parents. Extends medical assistance to two-parent AFDC families with children under 18 where at least one of the parents is unemployed (HB 1245, Chapter 89-334, 1989 Laws, effective 10/1/90)

ELIGIBILITY

MCH: Increases income eligibility for pregnant women from 100% to 150% and adds infants under 1 year to eligible population; exempts counties from contributing funds for this Medicaid expansion. (SB 255, Chapter 89-275, 1989 Laws, effective 7/1/89)

Transition-to-Work: Eligibility for medical assistance to two parent AFDC families (see above) is limited to 6 months in any 12 month period; exceptions may be defined by the Department. (HB 1245, Chapter 89-334, 1989 Laws, effective 10/1/90)

REIMBURSEMENT

DSH: Establishes criteria and methodology used by the DHRS to determine a hospital's disproportionate share rate. To qualify for reimbursement as a DSH, a hospital's total of Medicaid days plus charity care days must equal or exceed 7% of total adjusted patient days. Hospitals that participate in the Regional Perinatal Intensive Care Center (RPICC) program will be eligible to receive payments as a DSH; reimbursement rates are designated by a specified formula. These particular providers are also subject to additional requirements regarding: (1) staffing ratios; (2) quality assurance; (3) data collection; (4) consumer evaluation, education and counseling; and

(5) support services such as backup, referral and transportation. Sets up grant program for reimbursing DSH who participate in the RPICC program. A hospital may receive funds from the grant only if (a) its total revenues for patients treated under the program derive from the expansion of Medicaid eligibility (from 100% to 150%, see above); and (b) the disproportionate share payments do not equal the revenues received the perinatal intensive care program for the fiscal year ending 6/30/89. Total reimbursement may not exceed the difference necessary to reach the hospital's revenues under the RPICC program for the fiscal year 1988-89. (SB 255, Chapter 89-275, 1989 Laws, effective 7/1/89 only for the 1989-90 fiscal year)

MCH Providers: Requires the DHRS to establish groupings and reimbursement rates for obstetrical and neonatal care for high-risk pregnant Medicaid eligibles and neonates with life-threatening conditions. These rates will apply to physicians who provide services in Regional Perinatal Intensive Care Centers. Eliminates the inpatient day cap for children under 1 year of age whose family income is below 150% of the federal poverty level. (SB 255, Chapter 89-275, 1989 Laws, effective 7/1/89)

Nursing Homes: Base payment for optional state supplementation funds for mentally ill nursing home residents will be determined by the DHRS based on appropriated funds. Base payment does not include personal needs allowance. (SB 1298, Chapter 89-294, 1989 Laws, effective 7/1/89)

ADMINISTRATION & MANAGEMENT

Advisory Council: Outlines purpose and responsibilities of Medicaid Advisory Council and establishes membership; council will meet no more than quarterly. (SB 92, Chapter 89-92, 1989 Laws, effective 10/1/89.)

Prepaid/Capitated Contracts: Amends current statues to prohibit the DHRS from contracting with any pre-paid plan in which any officer, manager or owner has more than 5% of stock, or the plan has been found guilty of fraud, antitrust embezzlement, theft, forgery, tax evasion, falsification of records, or any other crime relating to the provision of health care services on a prepaid or capitated basis. (HB 746, Chapter 89-311, 1989 Laws, effective July 5, 1989)

OTHER MEDICAID RELATED STRATEGIES

LTC/Medicare Catastrophic Coverage Act of 1988: Requests the U.S. Congress to review the MCCA to restore equity in financing of health care for the elderly and to develop a system of coverage for truly catastrophic conditions, including but not limited to long-term care for elderly who reside in nursing homes, residential care facilities or their own homes. (HB 1596, Memorial, adopted 6/21/89)

FLORIDA CONTINUED

INDIGENT CARE & UNINSURED PROGRAMS

Uncompensated Care Funding under the "Public Medical Assistance Trust Fund" (PMATF):

New Commission: Establishes the "Florida Commission for the Funding of Indigent Health Care" to review the use funds from the PMATF. The commission will consist of 19 members representing the state legislature, private industry, consumer advocates, the Governor's office and the Commissioner of Insurance. Appointments must be made by 8/1/89. The commission must submit recommendations to the governor and the legislature on the following issues: (1) sources of funding for poor and uninsured, including "sin taxes"; (2) the continued existence of the PMATF; (3) the adequacy of current reimbursement methods; and (4) the need to modify current reimbursement methodologies to prevent excess bed capacity and inefficient operations. Appropriates $100,000 from PMATF for commission operations. (SB 255, Chapter 89-275, 1989 Laws, effective 7/1/89)

Psychiatric Hospitals: Allows psychiatric hospitals to provide acute mental health services to indigent mentally ill individuals as well as access the PMATF for reimbursement. up to but no more than the amount they contributed to the PMATF in the previous year. Each year on October 1 beginning in 1989, the Health Care Cost Containment Board (HCCB) shall calculate a per diem reimbursement rate for specialty psychiatric hospitals for the provision of acute mental health services equal to its operating costs per inpatient day. Reimbursement rates shall be calculated using the most recent audited actual costs data received by HCCB, cost data received by August 15 for this year and every year subsequently, adjusted for inflation. Hospitals will be reimbursed quarterly. Establishes referral process by the department to participating specialty hospitals for the provision of psychiatric services to mentally ill indigents. (SB 220, Chapter 89-355, 1989 Laws, effective 7/1/89)

GEORGIA

BENEFITS & COVERAGE

Medically Needy/Elderly: Expands services to optional medically needy population; provides coverage for aged, blind, disabled, and over 65 who qualify under AFDC income and resource requirements. (HB 145, 1989 Laws, effective 4/1/90)

ELIGIBILITY

Nursing Homes: Capped income eligibility for nursing home residents at 300% of the federal budget rate (FBR) thus eliminating the second step in their income eligibility process.

REIMBURSEMENT

Prescription Drugs:

Competitive Bidding: Establishes Medicaid Prescription Drug Bidding & Rebate Program. Requests sealed bids from manufactures for specified drugs; manufacturers who receive contracts will be given rebates for the amount of the bid price for drugs (for which they awarded a contract) when those drugs are supplied to Medicaid recipients. If no acceptable bids are received, Department of Medical Assistance (DMA) may select single supplier for a drug. (HB 70, Act 539, 1989 Laws, effective 4/10/89)

Formulary: Urges DMA to establish a drug formulary which includes only items determined to be cost-effective and necessary, and to study other options for controlling drug expenditures including but not limited to purchase, bidding, reduced pricing or elimination of coverage. (SR 104, adopted 2/13/89; and HR 196, adopted 2/28/89)

ADMINISTRATION & MANAGEMENT

Nursing Homes/Preadmission Screening: Urges Congress and HCFA to be sensitive to needs of the mentally ill/retarded and adopt regulations that allow maximum flexibility of states to serve this population. Also urges approval of the state's alternative disposition plan for mentally handicapped nursing home residents. (SR, adopted 1989)

GEORGIA CONTINUED

OTHER MEDICAID RELATED STRATEGIES

Nursing Home Reforms: Urges Congress and HCFA to (1) be sensitive to needs of mentally ill/retarded; (2) adopt regulations that allow maximum flexibility of states to serve mentally ill/retarded population; and (3) approval of Alternative Disposition Plan as the state's implementation plan for treatment services of mentally ill residing in nursing homes. (SR 202, adopted 3/7/89)

INDIGENT CARE & UNINSURED PROGRAMS

New Commission: Creates "Access to Health Care Commission" to review existing laws and programs, including Medicaid, develop alternatives for removing barriers to access, and engage in public hearings and other data collection efforts as needed. Preliminary report is due to the Governor on 12/1/89, and a final report is due 12/1/90. Commission will be abolished 12/1/90. (HR 162, adopted 4/19/89)

State Risk Pools: Creates the "Georgia High Risk Health Insurance Plan", a risk pool for uninsurables; establishes a commission to administer the program as well as eligibility criteria and coverage requirements. The pool will be financed through appropriations and public and private contributions. The law becomes effective on July 1, 1989 only to appoint the commission and establish elements of the plan by the governing board. The rest of the Act will become effective upon state appropriations for the pool. (SB 267, Act 684, 1989 Laws, effective 7/1/89)

HAWAII

BENEFITS & COVERAGE

No Changes

ELIGIBILITY

MCH: Extends eligibility to pregnant women and infants under 1 year with family incomes up to 185% of the federal poverty level; extends eligibility to children from ages one up to eight (not inclusive) whose family incomes do not exceed 100% of the federal poverty, and older children to the extent possible under optional federal rules. (HB 62, Act 393, 1989 Laws, effective 1/1/90)

REIMBURSEMENT

Adult Residential Care Homes: Increases level of care (LOC) payments for adult residential care homes as follows: For Facility Type I--LOC I increases by $70, LOC II increases by $105, and LOC III increases not less than $145. For Facility Type II--LOC I increases not less than $124, LOC II increase no less than $105, and LOC III increases not less than $145. (HB 913, Act 379, Laws 1989, effective 7/1/89)

Nurses: Strongly urges the Department of Health to recognize registered nurses as qualified medicaid health care service providers to allow reimbursement of their services under Medicaid. The state is continuing to work out the details for implementation. (HR 230, HCR 212, both adopted 4/27/89)

ADMINISTRATION & MANAGEMENT

LTC/Discharge Planning: Requests Legislative Reference Bureau to conduct a study of discharge planning and to provide recommendations and options for coordination of services for patients requiring or entering the long-term care system. (HR 336, adopted 4/27/89)

MCH: Requests Department of Human Services to issue a policy clarification regarding services to pregnant women who live in areas with no designated Medicaid provider to ensure timely service and eligibility determination and that the department to take measures to encourage and facilitate designation of facilities in areas with no providers. Three additional providers have been recruited for this purpose. (HR 381, 1989 Laws, adopted 4/27/89)

Nursing Homes/Nurse Aide Training: Notes that 14 states report that nurses aides are regulated through their state boards of nursing and 14 other states are introducing legislation or regulations related to training programs or qualifications for nursing aides in long-term care facilities. Requests the Hawaii Nurses Association to establish a task force to investigate the feasibility of regulating nurse assistants. May include representatives from the state board of nursing, the department of health, the department of commerce and consumer affairs, and others. Findings to be reported prior to the 1990 regular session. (SR 197, adopted 1989)

Utilization/Federal Participation: Requests legislative auditor in coordination with the Departments of Health, Human Services, Education, the University of Hawaii School of Public Health, the Hawaii Public Health Association, and the Commission on the Handicapped conduct study of Medicaid utilization to develop strategic plan for more efficient use of medicaid funds. **(HR 275, HCR 256,** both adopted 4/27/89)

OTHER MEDICAID RELATED STRATEGIES

Medicare Catastrophic Coverage Act: Requests U.S. Congress to cease implementation of Medicare Catastrophic Coverage Act because of its unfair impact on the elderly. (House Concurrent Resolution 362, adopted 3/27/89)

Mental Health: Urges the Department of Health to amend State Medicaid Plan to include mental health services; also urges the Department investigate program options such as waivers to improve delivery of services to mentally ill population. (HCR 397, adopted 4/27/89)

INDIGENT CARE & UNINSURED PROGRAMS

"Gap Grout>" Insurance: Establishes state health insurance program within the Department of Health to provide coverage to the "gap group" of uninsured; appropriates $4 million for FY 1989-90 and $10 million for FY 1990-91. (HB 1906, Act 378, Laws 1989, effective 6/26/89)

Mental Health Providers: Allows professionals who determine that disabled persons eligible for public assistance are mentally impaired to provide treatment when appropriate providers are in short supply (for example, in rural areas). (SB 1875, Act 12, 1989 Laws, effective 4/11/89)

Personal Care Services: Current income eligibility standards for health care services to indigent adults is between 200% and 400% of the Medicaid income eligibility level. This law lowers adult indigent income eligibility for personal care services to 100% - 300% of Medicaid levels and eliminates income floor (100% Medicaid income eligibility) for personal reserve retention. Defines personal care services. (HB 361, Act 39, 1989 Laws, effective 7/1/89)

HAWAII CONTINUED

Public Assistance Allowance: Increases assistance allowance from 60% to 62.5% of the standard need allowance indexed to changes in the federal poverty level on July 1 of each year thereafter. (HB 362, Act 154, 1989 Laws, effective 7/1/89)

IDAHO

BENEFITS & COVERAGE

No changes

ELIGIBILITY

Transfer of Assets: (HB 117, Chapter 67, 1989 Laws, effective 7/1/89)

AFDC: AFDC shall not be granted to anyone who has transferred or divested him/herself of assets within 6 months of applying for AFDC, unless the applicant demonstrates that he or she has caused the assets to be transferred back or met subsistence and medical care costs exclusive of any obligation for support prior to the transfer.

Nursing Homes: Income determination for Medicare eligible couples will include community assets regardless of whether the couple is living together or are separated as a result of one spouse entering a medical institution.

REIMBURSEMENT

Nursing Homes:

Capital Improvements: Allows nursing homes to upgrade property without prior approval and broadens language of reimbursable repairs to include replacement, remodeling, and renovation. When property repairs result in a change in more than 1 year of age for purposes of determining the rental rate, the maximum allowable increase in rent is raised from 1/2 of the difference between the base rate and the new rate to 3/4 of that difference but may not be lower than the rate in effect on December 31, 1988. Requires adjustment of grandfathered rate to compensate facility owner for major repairs, replacement, renovations, remodeling, and expansions initiated prior to 4/1/85 and completed within the 1985 calendar year. If facility upgrades were initiated after 1/1/86, the grandfathered rate will be the higher of the current grandfathered rate or the actual depreciation, amortization, and interest for the current year plus the per diem of the cost of the upgrade. The change in rate may not be greater than 3/4 of the difference between the current grandfather rate and the adjusted property base. (HB 304, Chapter 417, 1989 Laws, effective 7/1/89)

Payments: Provides that cost reports of SNFs and ICFs be filed within a certain time period; provides for an annualization of cost reports. Allows the Department of Health and Welfare to determine interim rates for nursing homes based on the most recently filed cost report instead of the last audited report. (SB 1211, Chapter 425, 1989 Laws, effective 7/1/89)

LTC: Gives authority to reimburse at a special rate facilities who provide services to patients with long-term care needs beyond the normal scope of the facilities, including but not limited to ventilator assisted patients, certain pediatric patients, certain comatose patients, and certain patients who require nasogastric or intravenous feeding devices. Payment for such services is in addition to other payments under Medicaid. Facilities' costs of providing extra long-term care services will not be included in the computation of Medicaid reimbursement rates. Also reimburses oxygen concentrators if used in lieu of bottled oxygen for long-term care patients. (SB 1209, Chapter 362, 1989 Laws, effective 7/1/89)

ADMINISTRATION & MANAGEMENT

Nursing Homes:

Licensure: Deletes reference to provisional licenses which are no longer available and provides that fees be set by board rule no to exceed $85. (HB 42, Chapter 31, 1989 Laws, effective 7/1/89)

Preadmission Screening: Petitions HCFA to repeal preadmission screening of mentally ill and mentally retarded patients in nursing homes as mandated in the OBRA '87. (SJM 101, adopted 3/27/89)

OTHER MEDICAID RELATED STRATEGIES

Medicare Catastrophic Coverage Act: Urges the U.S. Congress to address the issues raised by the implementation of the Medicare Catastrophic Coverage Act and to substantially revise the funding mechanism to protect the limited resources of the elderly. (HJM 3, adopted 2/27/89)

INDIGENT CARE & UNINSURED PROGRAMS

Residency Reauirements: Redefines and clarifies concept of "residency" for eligibility determination for medical assistance to indigent patients. (SB 1275, Chapter 374, 1989 Laws, effective 4/5/89)

ILLINOIS

BENEFITS & COVERAGE

No Changes

ELIGIBILITY

AIDS: Exceptional medical care (i.e., the level of care required by persons who are medically stable for discharge from a hospital, but who require acute intensity hospital level care by physicians, nurses and ancillary service specialists) is redefined to include persons with acquired immunodeficiency syndrome (AIDS) or a related condition. (HB 741, Public Act U-1206, 1989 Laws, effective 1/1/89)

MCH: Establishes "Prenatal and Newborn Care Program" to provide services to pregnant women whose family income does not exceed 100% of the federal poverty standard. Allows the state to increase income eligibility standard. The Department of Public Health must consult with the Infant Mortality Reduction Advisory Board on the implementation of this program. (HB 1091, Public Act 864360, 1989 Laws, effective 1/1/90)

Transfer of Assets: Increases time period under transfer-of-assets provisions for Medicaid eligibility from 24 to 30 months. More closely defines a nursing home client's financial needs as the average cost in a nursing facility to a private patient. (SB 1010, Public Act 86-431, Chapter 23, 1989 Laws, effective 1/1/90)

Transition to Work: Extends medical assistance to persons who become ineligible for aid to families with dependent children (AFDC) due to employment earnings for up to 12 months. (SB 376, Public Act 86-909, 1989 Laws, effective 4/90)

REIMBURSEMENT

DSH: Makes adjustment in payment to hospitals that: (1) meet the federal Medicaid criteria for a disproportionate share hospital; (2) are in health manpower shortage areas with high medical assistance patient loads; or (3) are children's hospitals. (SB 150, Public Act 86-268, 1989 Laws, effective 7/89)

Nursing Homes: Clarifies that payment to nursing homes for support services (i.e., laundry, dietary, housekeeping, utilities and administration) will be calculated by assessing the individual facility's per diem cost relative to the average per diem cost of all nursing homes within the Health Service Area (HSA). A nursing wage

adjustment factor will be included in computing nursing home rates. (SB 384, Public Act 86-705, 1989 Laws, effective 1/1/90)

ADMINISTRATION & MANAGEMENT

Hospital Audits:

Requires the Office of the Auditor General to conduct an annual program audit of the Illinois Competitive Access and Reimbursement Equity Program (ICARE) to examine the following issues: (1) savings generated by the program; (2) impacts on access as measured by a) the number of days of free care, b) travel time and distance of recipients, c) physician availability, and d) financial condition of hospitals in medically underserved areas; (3) fairness of contracts; (4) disproportionate share hospital adjustments; and (5) adherence to the contracts. A report must be issued by April 1 of each year. (SB 733, Public Act 86-735, Chapter 111, 1989 Laws, effective 9/1/89)

When authorized by the Legislative Audit Commission, the auditor general is directed to conduct an audit of any hospital that receives 10 percent or more of its gross revenue from the Medicaid program. (HB 2038, Public Act 86-617, Laws 1989, effective 1/1/90).

Local Reimbursement for Public Assistance: Requires an annual reconciliation of amounts allocated to the local governmental units by the Department of Health Services (DHS) to supplement local funds. Allows the DHS to provide a special allocation of funds to the local governmental units to meet financial needs in the event of a sudden increase in caseload or unexpected increase in administrative expenses where the local unit has insufficient local funds to provide necessary assistance. (SB 1010, Public Act 86-431, Chapter 23, 1989 Laws, effective 1/1/90)

LTC/Trust Fund: Creates the Long-Term Care Monitor/Receiver Fund to finance monitors and receivers of nursing homes. Fund will be supported by a $200 application fee required by nursing homes seeking a license. (HB 2649, Public Act 86-663, 1989 Laws, effective 9/89)

Nursing Homes:

Nurse Aide Training: Amends the Nursing Home Care Act. This act authorized the department to prescribe a curriculum for training nurse's aides, orderlies and nurse technicians. Lists qualifications for applicants: at least 16 years old, of good moral character, be able to speak and understand English, provide evidence of employment or occupation and residence for the past 2 years. Have completed at least 8 years of grade school or provide proof of equivalent knowledge, begin course within 45 days of employment and complete course within 120 days. Nurse's aides already employed by the same facility for one year (or more than one facility for 2 years) may take a

proficiency exam in lieu of the training course. The amendment to the existing act requires that SNF and ICF facilities treating persons with Alzheimer's disease and related dementia receive 12 hours of training in the care and treatment of such residents under the certification program. (SB 1186, PA 86-440, 1989 Laws)

Patient Rights: Requires nursing homes to inform all new residents of their rights under new spousal impoverishment laws as enacted under the Medicare Catastrophic Coverage Act of 1988. (SB 495, Public Act 86-410, 1989 Laws, effective 8/30/89)

Personal Needs Allowance: Provides that funds placed in a nursing home residents' personal account as a personal needs allowance can only be used for the benefit of the resident. (HB 296, Public Act 86-486, 1989 Laws, effective 1/1/90)

Physicians: Exempts physicians and group practices from the financing and ownership disclosure requirements that apply to other providers who have a relationship with firms and business providing health care services in the state under the medical assistance program. (SB 1008, Public Act 86-430, 1989 Laws, effective 7/1/90)

OTHER MEDICAID RELATED STRATEGIES

Managed Care Demonstration: Authorizes the Department to develop, implement and evaluate a Primary Care Sponsor System. the purpose of the demonstration program is to control the costs of providing medical care to Medicaid recipients by having one provider responsible for managing all aspects of a clients care. (SB 734, Public Act 86-1004, 1989 Laws)

Nurses/Studies: Requires the Department to determine what incentives might be necessary to attract nurses to practice in medically underserved areas of the state. Based upon the results of this study, the Department may implement a nurse incentive program, subject to available funding. (SB 734, Public Act 86-1004, 1989 Laws)

INDIGENT CARE & UNINSURED PROGRAMS

No Changes

INDIANA

BENEFITS & COVERAGE

AIDS/Case Requests permission to amend state medical assistance plan to provide optional targeted case management services to population with AIDS and AIDS related conditions; expires 1/1/91. (HB 1753, 1989 Laws, effective 5/5/89)

MCH:

Case Management: Adds case management services for pregnant women. (SB 449, 1989 Laws, effective 1/1/90)

State wards: Expands coverage to Medicaid eligible children under 18 who are in need of services who are wards of county public welfare department by order of the court. The county is responsible for paying the portion of medical services not covered by Medicaid. (HB 1801, 1989 Laws, effective 7/1/89)

Home Health: Adds personal care services under a 1915(c) home health care waiver. (SB 538, 1989 Laws, effective 5/2/89)

Prescription Drugs: Allows pharmacist to substitute the generically equivalent drug product unless otherwise specified by practitioner in writing using the words "Brand Medically Necessary", effective 7/1/89. Also applies to prescription drugs filled under Medicare, effective 1/1/90. Requires each prescription to have two signature lines at bottom; below those lines must appear in print the words "dispense as written" on the left and "may substitute" on the right. For prescriptions under Medicare, substitutions may be made only is practitioner has signed both lines or indicated over the telephone to the pharmacist that a substitution may be made, in which case the pharmacist must sign the form. Must also have consent of patient that practitioner may select generically drug product, effective 1/1/90. (HB 1668, 1989 Laws)

ELIGIBILITY

DD/Handicapped: Broadens services to developmental disabled population to include all individuals who are admitted to a mental health institution for observation, diagnosis, or treatment". Redefines developmental disability--eliminates specific disabilities such as cerebral palsy and epilepsy, includes disabilities attributable to both mental and physical impairments that (1) are manifest before the age of 22; (2) will require continuous and/or individually tailored care for an extended or indefinite period of time; and (3) result in functional limitations in 3 of 7 specified categories. Defines eligibility criteria for mentally-ill individuals as follows: a person

is eligible if one (1) has been determined by an Indiana state qualified mental health professional to have significant mental illness or emotional impairment; **(2) is** currently an inpatient or resident of, in the process of being admitted to, or being transported to a facility providing care or treatment; or (3) involuntary confined in a municipal detention center for reasons other than serving a sentence resulting from conviction of a crime. (HB 1071, 1989 Laws, effective 5/9/89)

MCH: Expands eligibility for pregnant women and children up to 3 years of age on phase-in basis--100% poverty after 6/30/89, 125% after 6/30/90, and 150% after 6/30/91. (SB 449, 1989 Laws, effective 8/1/89)

Taxable Income: Allows individuals who are receiving medical assistance to retain from their adjusted gross income the amount equal to their state and local tax liability; this amount will not be considered in income eligibility assessment for medical assistance. Pending approval from HCFA. (SB 339, 1989 Laws, effective 1/1/89)

REIMBURSEMENT

DD/Handicapped: Requires centers for developmentally disabled persons that receive money from the Mental Health Centers Fund to use new eligibility criteria for reimbursement by the department of mental health. Requires state department to pay each eligible claim submitted by a provider under the medical assistance program within 45 days after receiving all information necessary to determine if claim is payable. (HB 1071, 1989 New Laws, effective 5/9/89)

Home Health: Relatives of Medicaid eligibles trained to provide homemaker and personal care services to eligibles may be reimbursed for services provided if provision of those services results in financial hardship for the relative. Funding for these services will come from federal social services block grants or Title XIX (see Administration and Management). (SB 538, 1989 Laws, effective 5/2/89)

Hospitals:

Rate-Setting: Allows DPW to determine reimbursement rates under payment systems that are prospective, retrospective, or any combination thereof. (SB 449, 1989 Laws, effective 5/5/89)

TB Hospitals: Payments to TB licensed hospitals must be in accordance with prospective payment rate for service. Allows Department of Public Welfare (DPW) to set per diem rate for services; and to negotiate a Medicaid payment rate for services provided in TB hospital prior to implementation of prospective payment system; expires 7/1/90. (SB 450, 1989 Laws, effective 7/1/89)

INDIANA CONTINUED

ADMINISTRATION & MANAGEMENT

Developmentally Disabled: (HB 1071, 1989 Laws)

MMIS: Requires state department to develop either a 24 hour telephone system or computerized information system to give providers immediate access to information to determine if an individual is eligible for medical assistance (effective 5/9/89).

Protection and Advocacy Commission: Extends term of first time commission members from 2 to 3 years. Expands scope of duties to include advocacy services for mentally ill individuals and individuals seeking or receiving vocational rehabilitation services. Merges advocacy commission for developmentally disabled with the rest of Indiana's protection and advocacy services (effective 7/1/89, expires 7/2/89). Member of advocacy commission for developmentally disabled shall be member of advocacy commission until term would have expired under old law (expires 7/2/92).

Home Health Training Programs: Establishes program to train relatives of eligible individuals to provide homemaker and personal care services to those eligibles. (SB 538, 1989 Laws, effective 5/2/90)

MCH: Requires annual evaluation of effectiveness of expanding services to pregnant women and children up to 3 years of age submitted to legislature no later than January 1 of each year (SB 449, 1989 Laws, effective 8/1/89)

Prescription Drugs/Advisory Committee: Sets up advisory committee to participate in AMA's drug diversion program (PADS II); expires 6/30/93 (effective 1/1/90). Advisory committee on controlled substances must issue a written report to the general assembly before 10/1 of each year information on multiple copy prescriptions and the number of actions taken against a practitioner as a result of participation in AMA's PADS program; expires 6/30/93. (effective 5/5/89) The committee must submit any relevant information collected under PADS II to the drug diversion advisory committee in a timely fashion (effective 1/1/90). (HB 1668, 1989 Laws)

Providers: Prohibits providers from soliciting services to people who are eligible to receive for medical assistance under medicaid; law does not prohibit providers from advertising to the general public, children units, or special service populations such as ventilator-dependent patients, AIDS victims, or Alzheimer's patients. (HB 1270, 1989 Laws, effective 7/1/89.)

Recovery: Establishes a fund to receive money collected under the federally required enforcement process. Money in the fund must be used in accordance with federal statutes. (HB 1149, 1989 Laws)

INDIANA CONTINUED

OTHER MEDICAID RELATED STRATEGIES

AIDS: Allows Dept. of Human Services to provide resources to a nonprofit AIDS service organization to develop community action groups, coordinate information gathering, and develop model for provision of integrated services to HIV population. Expires 6/30/91. (HB 1753, 1989 Laws, effective 7/1/89)

Commission: Establishes health policy commission and representative advisory committee to examine access, cost, and preventive health care issues. Interim report is due to governor by 11/1/90 and final report is due 11/191; expires 1/1/92. (SB 385, 1989 Laws, effective 5/5/89)

Studies:

Developmental Disabilities: Requires the planning council on developmental disabilities to (1) study the feasibility and fiscal impact of bringing Indiana's definition of development disability into conformity with the federal definition; (2) compare the state's per capita spending on people receiving benefits who are developmentally disabled to those who receive benefits and are disabled but not developmentally disabled; and (3) prepare a report with the council's findings, conclusion, and legislative recommendations. This report must be filed with the governor and legislative council by 9/1/90. Legislation expires 9/2/90. (HB 1071, 1989 Laws, effective 5/9/89)

LTC: Requires budget committee to study consumer costs of purchasing state-approved qualified LTC plan and present findings to Governor by 10/1/90, expires 12/31/90. (SB 363, 1989 Laws, effective 5/1/87)

Waivers:

AIDS: Requests from DHHS a waiver to provide case management services to individuals with AIDS and AIDS related conditions under Medicaid. Expires 12/1/90. (HB 1753, 1989 Laws, effective 7/1/89)

Home Health: Requests waiver from DHHS before 1/1/90 to reimburse relatives of Medicaid eligibles trained to provide homemaker and personal care services to eligibles; limited to cases where provision of that care results in financial hardship for the relative; expires 1/1/92 (SB 538, 1989 Laws, effective 7/1/90)

INDIGENT CARE AND UNINSURED PROGRAMS

No Changes

IOWA

BENEFITS & COVERAGE

MCH/Case Management/EPSDT: Expands targeted case management program for pregnant women and EPSDT services to children to all areas of the state (SB 538, 1989 Laws, effective 8/15/89)

ELIGIBILITY

MCH: (SB 538, 1989 Laws, effective 7/1/89)

SB 538 appropriates $1,155,000 in state funds for implementation of the Medicaid expansions. This draws down approximately $1,800,000 in increased federal funds. The Medicaid expansions should eliminate much of the need for the current state decentralized obstetrical payment program.

1. Expands coverage to include pregnant women and infants with family incomes at or below 185% of the federal poverty level, up from 150%;

2. Establishes presumptive eligibility by qualified health providers; includes ambulatory prenatal care services for up to 14 days under presumptive eligibility until application is filed and up to 45 days while application is pending;

3. Expands eligibility to include children up to age 6 in 1989 and children up to age 8 in 1991 whose family income is below the federal poverty level;

4. Treats pregnant women as if child were born for income eligibility determination;

5. Other populations targeted for eligibility expansion: (1) individuals who would have been eligible for state or federal supplemental assistance except for COLA increases in federal social security benefits; (2) individuals whose spouses are deceased and who are ineligible for social security benefits due to the elimination of actuarial reduction formula of benefits and subsequent COLAs; (3) individuals who are at least 60 years of age and are ineligible for (a) Medicare Part A and (b) supplemental assistance because of receiving widow or widower benefits; (4) disabled individuals under 18 who receive parental social security benefits and who are ineligible for supplemental assistance because of receiving those benefits;

6. "Tools of the trade" are exempted from being considered as resources in income eligibility determination;

7. Allowable resources to qualify for Medicaid under the AFDC-medically needy and SOBRA programs are expanded to $10,000 regardless of family size. Only monetary resources (e.g. bank accounts, stocks, bonds, etc.) are considered toward the $10,000 limit;

Transfer of Assets: Resource tests to determine Medicaid eligibility for Medicare recipients will now include resources transferred to an individual's spouse before 10/1/89 and to other individuals before or after 7/1/89. (SB 117, 1989 Laws, effective 7/1/89)

REIMBURSEMENT

Medicare Buv-in: Medicaid payments may be used towards payment of premiums, copayments or deductibles under Medicare. (SB 117, 1989 Laws, effective 7/1/89)

Paver of Last Resort: Codifies existing practice of deeming Medicaid the payer of last resort. (HB 779, 1989 Laws, effective 8/15/89)

Psychiatric Services for Children: Psychiatric medical institutions for children licensed before 5/1/89 will be reimbursed at the approved Medicaid rate until 9/1/89, at which time the foster group care rate goes into effect. Those institutions licensed on or after 5/1/89 may bill the Department of Medical Assistance for actual costs up to $120/day but will initially be reimbursed at the group foster care rate. If HCFA approves the proposed amendment to the state Medicaid plan to include coverage of services in a psychiatric medical institution for children, the licensed institution will be reimbursed at the established Medicaid rate retroactive to either the effective date of the amended plan or the date when the institution was enrolled in the Medicaid plan, whichever is later. Requires the Department of Human Services to develop a permanent reimbursement methodology by 7/1/89. (SB 540, 1989 Laws, effective 6/1/89)

ADMINISTRATION & MANAGEMENT

Managed Care/HMO Enrollees: Requires Department of Human Services (DHS) to examine the health impacts and the use of primary and preventive health care services for AFDC recipients enrolled in HMOs. (SB 538, 1989 Laws, effective 8/15/89)

MCH:

MMIS: Requires DHS to make use of the MMIS system to identify Medicaid children in need of preventive health services and to review and evaluate birth outcomes of children born under the Medicaid program. (SB 538, 1989 Laws, effective 8/15/89)

Outreach/Care Coordination: Requires department to provide technical assistance to other state agencies to develop outreach centers which provide and coordinate public services to pregnant women (HB 779, 1989 Laws, effective 8/15/89)

Advisor-y Committee: Adds representatives from the Iowa Hearing Aid Society (IHAS) and the Iowa Speech, Language, and Hearing Association (ISLHA) to the Medicaid Advisory Committee. (SB 402, 1989 Laws, effective 7/1/89)

Nursing Home/Patient Rights: Brings Iowa law into conformance with federal requirements under OBRA '87. Establishes procedures for investigation of alleged complaints of abuse or neglect of a patient against a health care facility; the department must submit to the department of elder affairs every 6 months the name of each health care facility in its area for which the care review committee has failed to submit a report. (SB 31, 1989 Laws, effective 8/15/89)

Pharmaceuticals/Prescription Drugs: Requires DHS to adopt rules for ICFs to execute separate written contracts for pharmaceutical vendor services and consultant pharmacists; contract requires monthly drug regimen review reports; reimbursement will be based on fair market value; requires study on possible certification of consultant pharmacists to general assembly by 1/15/91. (SB 538, 1989 Laws, effective 8/15/89)

Recovery: Allows DHS to attempt to recover payment for medical services to a Medicaid recipient in the event that the Medicaid recipient wins a settlement, award or judgement against a third party if medical expenses for which the department has paid are involved unless (1) the medical assistance director or the director's designee provides a written agreement to the contrary; or (2) the claim for the recovery of medical expenses is barred by a statute of limitation. If a wrongful act leads to the death of a Medicaid recipient, the department may recover from the collected damages the amount that was paid for medical assistance for the Medicaid recipient from the time of injury to the time of- the recipient's death. (SB 412, 1989 Laws, effective 7/1/89)

Selective Contracting Study: Requires study of selective contracting arrangements with health care providers used under medical assistance programs in other states; report is due to the legislature by 1/29/91. (SB 538, 1989 Laws, effective 8/15/89)

OTHER MEDICAID RELATED STRATEGIES

Health Care Utilization and Information Task Force: Requires the Iowa Health Data Commission to provide certain publications on an annual basis that address issues of utilization, quality of care, and cost. The commission is required to contract for a study of health care utilization in Iowa for procedures for which national studies suggest there exists over-utilization and that are subject to wide variation of use in Iowa. The commission is required to convene a representative task force to oversee the

study review the results an identify ways to reduce inappropriate utilization o health care services; $100,000 has been appropriated for the study. (SB 538, 1989 Laws, effective 8/15/89)

MCH/Care Coordination: The Department of Public Health is directed to provide technical assistance to encourage coordination with DHS in providing services to pregnant women and children as well as to expand successful interagency projects currently operating in Ottumwa and Sioux City that provide clients with a single point to obtain maternal and child health services, WIC, food stamps, and Medicaid. The Department is also directed to develop rules to facilitate sharing of information about these programs to other parts of the state. The legislature has appropriated $37,000 to promote coordination; $483,000 to expand MCH services; and an additional $400,000 for use by the child health services to purchase additional physician services. (SB 538, 1989 Laws, effective 8/15/89)

Psychiatric Services for Children: Requires DHS to conduct needs assessment to determine the number and location of children who need the services of a psychiatric medical institution; department must report results and recommendations on limiting the number of children's psychiatric medical beds in the state to the general assembly by 1/1/90. (SB 540, 1989 Laws, effective 6/1/89)

Rural Health: Establishes an Office of Rural Health to (1) convene an advisory committee and act as a clearinghouse of information on rural health (appropriated $50,000); (2) provide technical assistance grants to rural communities for developing alternative health delivery systems and improve Medicaid and Medicare reimbursement through the establishment of rural health clinics and distinct part SNFs (appropriated $50,000); (3) provide grants for economic analysis of effects of restructuring health care delivery systems on rural health (appropriated $50,000 in seed money to obtain grants); (4) coordinate services for research on occupational health injuries (appropriated $15,000); and (5) make recommendations for a new category of medical facility licensure to respond to changing health needs of rural areas. Funds will be drawn from tax levy authorized under Chapter 347, which allows the County Board of Supervisors to levy taxes for public hospitals. (SB 538, 1989 Laws, effective 8/15/89)

INDIGENT CARE & UNINSURED PROGRAMS

Pilot Programs: (SB 538, 1989 Laws, effective 7/1/89)

Children: Sets up matching grants program for charitable and non-profit organizations to develop programs to provide health insurance coverage of primary care and preventative services to uninsured children; grant program must coordinates with existing public programs; requires an evaluation. The law appropriates $300,000 in FY 1990 and $450,000 in FY 1991 and 1992. In order to receive state matching funds, the

contract organization must raise $2 for every state dollar in 1990, $3 for every state dollar in 1991, and $4 for every state dollar in 1992.

Rural Health: Appropriates $500,000 to be used in the designated county or multicounty area to provide additional health care services to uninsured Iowans and to test the feasibility of providing an indigent health delivery system through a rural hospital.

Small Employer Participation in State METs: Requires the insurance division to develop proposal to provide technical assistance to small employers to identify, access and evaluate Multiple Employer Trusts (METS) within the state, and to assist small employers in overcoming barriers to participating in state METS; requires report to general assembly by 1/1/90. (SB 538, 1989 Laws, effective 8/15/89)

State Insurance Plan and Pool: Establishes a statutory framework for the provision of a health care insurance plan and pool within the state treasury to provide and fund primary and preventive health insurance to uninsured Iowans. The effective date is dependent upon enactment of a funding mechanism and detailing responsibilities of the state and employer participation. Requires health insurance study to address issues in funding and provision of these services with recommendations to be given to state legislature and general assembly by 1 l/l 5/90. $200,000 has been appropriated for the study. (SB 538, 1989 Laws, effective 8/15/89)

KANSAS

BENEFITS & COVERAGE

Child Support: Requires the state to provide full Child Support Enforcement (CSE) services to recipients of Medicaid who do not receive cash assistance. Previously, the state was only required to provide limited medical support services in such cases. The law also provides that upon application for CSE services, support rights are assigned to the Secretary of Social and Rehabilitation Services (SRS) regardless of whether or not the applicant is also receiving AFDC. This will eliminate additional paperwork for non-AFDC recipients for whom a written assignment had to be executed. (SB 378, 1989 Laws, effective 5/12/89)

ELIGIBILITY

MCH: Increases eligibility for pregnant women and infants to 150% of the federal poverty level and children up to age five to 100% of the FPL. (HB 2028, 1989 Laws, effective 7/1/89)

Transfer of Assets: Eliminates transfer-of-assets clauses from eligibility determination of Medicaid to bring Kansas statutes into compliance with federal law. The state statutes will be revived in the event that the preempting federal statutes be repealed or cease to apply to the Medicaid program. (SB 15, 1989 Laws, effective 4/12/89)

REIMBURSEMENT

Claims: Establishes conditions for which payment may be made on claims filed more than 6 months after services were provided. These include: (1) services provided to a child who was in the custody of the SRS at the time the service was provided; (2) claims submitted to Medicare within six months of when the service was provided, approved or denied by Medicare, and submitted to Medicaid within 30 days of the Medicare action; (3) claims deemed payable as a results of court action, administrative appeals or agency error; (4) claims for emergency care provided outside Kansas by providers who are not enrolled as Medicaid providers; (5) claims determined to be the result of extraordinary circumstances. (SB 302, 1989 Laws, effective 4/13/89)

Rural Hospitals/Inpatient Services: Urges the Secretary of the U.S. Department of Health and Human Services to adopt a policy or reimbursing rural hospitals for Medicare inpatient hospitals services at the same rate as urban hospitals for the same services. (HCR 5002, adopted 3/24/89)

ADMINISTRATION & MANAGEMENT

HCBS Waivers: Sets guidelines for operation of the Home and Community Based Services component of the Medicaid program. Authorizes the Secretary to conduct demonstration projects relating to the delivery of in-home care. Requires a report to the Governor and the Legislature by 10/1/90. (HB 2012, 1989 Laws, effective 10/1/89)

OTHER MEDICAID RELATED STRATEGIES

Home Health/Disabled Elderly: Under the "Senior Care Act", the Secretary on Aging is authorized to establish in-home services for Kansas residents over 60 years of age who have functional disabilities that restrict their ability to live independently. The Secretary is directed to designate area agencies on aging (AAA) to administer the program after an agency has submitted an acceptable program plan. In addition, the Secretary must: (1) establish the priority of services to be offered; (2) make grants from state funds to AAAs that qualify under the Act; (3) fix charges and collect sliding-scale fees that are based on a recipients ability to pay; (4) contract for services; and (5) adopt rules and regulations regarding eligibility determination, provider reimbursement and limitations on funds. After July 1, 1990, any funds granted to an area AAA under this act must be matched with funds from other than state or federal sources. Requires an annual evaluation of program effectiveness. A report is due to the Governor and the Legislature by 12/31 of each year. (SB 60, 1989 Laws, effective 7/1/89)

LTC Insurance: Allows long-term care insurance benefits as an exception to the prohibition against inclusion of any health and accident benefits in life policies. (HB 2383, 1989 Laws, effective 7/1/89)

INDIGENT CARE & UNINSURED PROGRAMS

Homeless Commission: Requires the Commission's final report to be submitted to the Governor and the legislature no later than 12/15/90. (The nine-member commission was established in 1988 to study access for services to homeless and medically indigent individuals. The commission will review access issues, determine priority groups and services to be provided, recommend financing options, review initiatives by other states, and make recommendations for short-term and long-term solutions.) (HB 2444, 1989 Laws, effective 7/1/89)

KENTUCKY

NO LAWS WERE PASSED IN THIS SESSION. ALL OF THE BELOW WERE PASSED BY REGULATION.

BENEFITS & COVERAGE

Dental Services: Implements the expanded orthodontic services within the dental program as of 7/1/89.

Durable Medical Eauipment: Expands coverage of durable medical equipment (DME) under Medicaid to allow coverage and participation of DME providers outside the Home Health Program. Enrollment and coverage began 4/1/89.

Hospice: Removes limit on the number of benefit days under the Hospice program. (effective 1/1/89)

MCH/Inpatient Hospital Services: Eliminates limit on inpatient hospital services for infants under one year. (effective 7/1/89)

Rehabilitation: Establishes a Brain Injury Program under SNF services to provide quality standards for intensive (rehabilitation) services; also increases reimbursement levels. (effective 7/1/89)

ELIGIBILITY

MCH: Eliminates resource test for pregnant women and infants with incomes up to 125% of poverty and for children under age two at 100% of poverty. (effective 6/1/89)

QMBs: Covers Medicare copayments, deductibles and payments for Medicare Part A and Part B premiums for certain low-income QMBs. (effective 1/1/89)

Single Filing Unit: Discontinues the use of the single filing unit for eligibility purposes. (effective 1/1/89)

Spousal Impoverishment: Adopts upper limits allowed by the Medicare Catastrophic Coverage Act for both spousal income and resource--ie: $1,500 for the monthly needs allowance and $60,000 for resources--when determining Medicaid eligibility for a spouse seeking long-term care coverage under Medicaid. (effective 1 0/1/89)

KENTUCKY CONTINUED

REIMBURSEMENT

DSH/MCH: Increases reimbursement rate for disproportionate share hospitals for services to infants under one year. (effective 7/1/89)

LTC/AIDS: Increases reimbursement for long-term care facilities to meet the care needs of persons with infectious diseases. (effective 7/1/89)

ADMINISTRATION & MANAGEMENT

Nursing Home Reforms:

Nurse Aide Training: Developed and implemented a Nurse Aide Training and Competency Evaluation Program for nurse aides working in nursing home throughout the state, as required under OBRA '87. Aides not demonstrating competency levels required by the evaluation are provided two opportunities to succeed and may repeat training if desired. The state provides study aids and curriculum for the training. Began in August of 1989.

Preadmission Screening: Implemented PASARR (Preadmission Screening and Annual Resident Review) of persons with a mental retardation or a mental illness diagnosis prior to admission to a long-term care nursing facility as required under OBRA '87. Persons requiring active treatment for either diagnosis must be routed to an appropriate care setting which can provide their care needs. Began 1/1/89.

OTHER MEDICAID RELATED STRATEGIES

No Changes

INDIGENT CARE & UNINSURED PROGRAMS

No Changes

LOUISIANA

BENEFITS & COVERAGE

No Changes

ELIGIBILITY

Transition-to-Work: Extends medical assistance for up to 1 year to individuals who lose eligibility as a result of gaining employment and who do not receive health benefits through work. Requires cost-sharing by recipient; allows the state to request a federal waiver to use matching federal funds for these additional services. (HB 1510, Act 566, Laws 1989, effective 10/1/89)

REIMBURSEMENT

LTC Pilot Project: Establishes a pilot project with the Department of Health and Human Services (DHHS) to allow selected long-term care facilities accredited by the Joint Commission on the Accreditation of Health Care Organizations to be eligible for reimbursement for services under Medicaid and Medicare. Participating facilities will be selected on a random basis from three categories--(l) 40 beds or less; (2) 41-125 beds; and (3) 126 beds or more--and may not include more than 15% of all licensed long-term care facilities in the state. In order to apply for participation in the pilot project, the facilities must have been licensed for at least two years and pay the costs of the licensing survey. (HB 774, act 180, Laws 1989, effective 1/1/90)

Pharmaceuticals: Memorializes US Congress to take action to stop HCFA from redefining the "Average Wholesale Price" for purposes of reimbursing the provision of pharmacy services under Medicaid. (HCR 112, adopted 6/21/89)

Physicians: Urges the Department of Health and Hospitals and the Department of Social Services to increase Medicaid payments to private physicians. (HCR 155, adopted 6/2/89)

Prescription Drugs: Requires expansion of the Medicaid formulary and establishment of the Medicaid Drug Program Committee. (SB 706, Act 403, Laws 1989, effective 6/30/89)

LOUISIANA CONTINUED

ADMINISTRATION & MANAGEMENT

Fraud: Increases penalty for Medicaid fraud to maximum fine of $10,000 or imprisonment up to 5 years (HB 1645, Act 300, Laws 1989, effective 7/1/89)

Human Services Task Force Recommendations: Urges Department of Health & Hospitals to implement recommendations of task force: (1) increase recovery activities of charity hospitals through improved tracking of medical assistance recipients; (2) improve through allocation of adequate resources the efficient operations of charity hospitals; (3) improve eligibility determination of disabled applicants; (4) consider recommendations made in Governor's Task Force on Education and (5) increase Medicaid eligibility to pregnant women and infants as put forth in SOBRA. (HCR 164, 6/20/89)

LTC: Authorizes and directs the Department of Health and Hospitals to establish a two-year moratorium on approval of Medicaid long-term care beds with the following exclusions: (1) intermediate care facilities for the mentally retarded; (2) applications made on or before May 10, 1989 for the approval of any new medicaid long-term care beds; and (3) maintaining an average annual occupance level of 99% for the four most recent reported quarters. (SCR 14, adopted 6/5/89)

Mental Health: Urges Department of Health and Hospitals to amend state Medicaid plan to increase number of leave days for students in state mental retardation residential facilities. (HCR 88 adopted 6/13/89)

Nursing Homes:

Compliance/Sanctions: Authorizes the Department of Health and Hospitals to adopt rules to implement the nursing home standards, sanctions and remedies mandated by federal law. These include the use of civil fines, payment denials, use of temporary management of a nursing facility, and alternative remedies to deter noncompliance and correct deficiencies. (SB 929, Act 719, 1989 Laws)

Preadmission Screening: Brings state statutes into compliance with federal requirements to screen all nursing home residents for mental illness and mental retardation. (Enrolled HB 602, Act 422, 1989 Laws, effective 9/3/89)

Pharmaceuticals: Urges Louisiana Department of Health and Hospitals to correct inequities in its "Explanation of Benefits" program that requires pharmacies to collect payment for services provided to medicaid recipients who have additional insurance from those third party payers. (HCR 15, adopted 6/7/89)

Prescription Drugs/Committee: Establishes Medicaid Drug Program Committee (SB 706, Act 403, Laws 1989, effective 9/3/89)

LOUISIANA CONTINUED

OTHER MEDICAID RELATED STRATEGIES

Children's Health Insurance: Adds both health insurance premiums and extraordinary medical expenses to the basic child support obligation under the state's "Guidelines for Determination of Child Support". (HB 18-XX, Special Extraordinary Session, Act 9, 1989 Laws, effective 10/1/89)

INDIGENT CARE & UNINSURED PROGRAMS

Access Study/Trust Fund: Creates "Indigent Health Care Trust Fund Authority" to study and develop a comprehensive plan to improve access to health care for indigent residents; 60% of any funds raised under the Authority through public or private sources will be used to match federal funds to increase eligibility of under Medicaid, to supplement the scope of existing services, to promote alternative delivery systems, and to increase reimbursement to providers under Medicaid. (HB 1601, Act 381, Laws 1989, effective 9/3/89)

Hospitals: Creates "Louisiana Health Care Authority" to developed comprehensive plan to revitalize the facilities and services of the state's charity care hospital system (HB 1186, Act 444, Laws 1989, effective 9/3/89)

Provider/Liability: Provides state protection for all health care providers who treat patients referred by a state hospital or other state facility when the patient is certified by the state hospital or other state facility as being eligible for admission to such a state facility and the treatment is provided without compensation or reimbursement from Medicaid or from any state or federal public assistance program. (SB 505, Act 826, 1989 Laws, effective 7/11/89)

MAINE

BENEFITS & COVERAGE

No Changes

ELIGIBILITY

Veterans Health: Any money a person receives as a result of judgement in a law suit on Agent Orange will not affect his or her eligibility for public assistance programs, including Medicaid. (HB 157, Chapter 566, 1989 Laws, effective 9/89)

REIMBURSEMENT

Nursing Homes: Revises nursing home reimbursement rules to clarify that flat rates will not be used and adjustments should be made to take into account changes in wages. Requires prospective reimbursement effective fiscal years beginning January 1, 1990 and thereafter. Prohibits upper limit cap unless reimbursement is projected to exceed Medicare upper limit. (HB 505, Chapter 567, 1989 Laws, effective 7/89)

ADMINISTRATION & MANAGEMENT

Nursing Homes/Preadmission Screening: Allows the Department of Human Services (DHS) to assess the medical needs of each nursing home applicant who is expected to become eligible for Medicaid within six months. Requires DHS to develop and disseminate to all nursing homes and the public its standards for medical eligibility for nursing homes. Also requires DHS to comply with the OBRA '87 -provision to screen each nursing home applicant for mental illness and mental retardation. (HB 1012, Chapter 498, 1989 Laws, effective 9/89)

Recovery:

Estate: Authorizes the state to seek claims against the estate of Medicaid recipients after their deaths when new payments or other assets are discovered that would have made the person ineligible for medical assistance. (SB 552, Chapter 397, 1989 Public Laws, effective 9/89)

Nursing Homes: Revises authority for collecting debts owed by nursing homes, particularly when ownership has changed. (SB 87, Chapter 34, 1989 Laws, effective 4/89)

MAINE CONTINUED

Commission: Creates the "Maine Human Development Commission" to advise the Governor and legislature on human development programs, including Medicaid. Includes submitting recommendations and comments on state plans. (HB 1185, Chapter 576, 1989 Laws, effective 9/89)

OTHER MEDICAID RELATED STRATEGIES

Child Support: Authorizes the state to seek information in child support cases, particularly the availability of health insurance. (SB 330, Chapter 255, 1989 Laws, effective 9/89)

LTC Commission: Creates Commission to study the level of services for Maine's elderly citizens, to review the financing of long-term care, as well as other services, and to report back to the legislature with findings and recommendations by 12/90. (HB 550, Chapter 58, 1989 Laws, effective 9/89)

INDIGENT CARE & UNINSURED PROGRAMS

DSH/Uncompensated Care Fund: Establishes the "Hospital Uncompensated Care and Governmental Payment Shortfall Fund" to pay hospitals most affected by bad debt, charity care and shortfalls in government payments. Funding will come from general state revenues and from assessments from all hospitals. (HB 954, Chapter 588, 1989 Laws, effective 9/89)

"Maine Health Program": Creates the "Maine Health Program", a program intended to meet the health care needs of uninsured residents who are not eligible for Medicaid. The program places a special priority on low-income children. Eligibility is extended to children under 18 years of age with family incomes at or below 125% of poverty and to persons age 18 or older with household incomes at or below 95% of poverty (scheduled to increase to 100% in 7/92). Individuals with incomes under 100% poverty will not be required to pay a contribution toward the premium; however, a premium contribution may be required for individuals with incomes above the poverty level, but fees may not exceed 3% of the household income. Recipients will receive the same range of benefits as Medicaid recipients. Recipients who require prenatal and nursing home care will be eligible for Medicaid. Employer-supported plans will be used where available. $10 million has been appropriated in the 1989-90 biennium to meet the cost of covering an estimated 13,000 individuals. (HB 954, Chapter 558, 1989 Laws, effective 9/89). **(Note that this program is different from the "MAINECARE" program, which is targeted to low-income uninsured workers. A brief description of this program has been included for clarification.**

"MaineCare" Program: The Maine Managed Care Demonstration Project is a three-year managed health insurance program for the low-income, working uninsured

developed by the Department of Human Services through a grant from the Robert Wood Johnson Foundation. The program was initiated in March of 1987 and began operation at the first of two demonstration sites in December of 1988. Operations at the second demonstration site are slated to begin in early 1990. Approximately 2,100 uninsured individuals are targeted for enrollment. In addition, 2,000 AFDC recipients will also be eligible to enroll in the managed care program on a voluntary basis. Premium subsidies are available to those subscribers whose household income is below 200% of poverty. Subsidies are supported by a legislative appropriation of $900,000.

MARYLAND

BENEFITS & COVERAGE

Managed Care/Pilot Programs: Directs the state to include, as appropriate, managed care pilot programs for Medicaid beneficiaries. Program will include a strong case management feature--one person will be designated to manage the delivery of health care services to a client--and cost-control features to prevent unnecessary utilization, and promote consumer education and preventive care. The law requires an annual evaluation of the managed care pilot projects to assess the health outcomes of the clients and the cost-effectiveness of the programs. (SB 794, Chapter 614, 1989 Laws, effective 6/1/89)

Home Health: Allows the state to include bedside nursing care for eligible program recipients, subject to availability of state and federal funds. (SB 794, Chapter 614, 1989 Laws, effective 6/1/89)

Nurse Anesthetists: Under new regulations, Medicaid now covers nurse anesthetists' services for all recipients. (Regulation, COMAR 10.09.39, effective 7/1/89)

Prescription Drugs: Copayments for prescription drugs under medicaid imposed 11/15/88 expire on 1 1/30/89. Beginning 12/1/89, recipients in federal categories will not be required to make copayments (reduced from 50 cents); copayments for recipients in state-only categories is reduced from $1.25 to $.50. Revisions affect all prescriptions, both new and refills for dates of services on or after 12/1/89. As before, copayments do not apply to individuals in state-only categories who are under 21, pregnant, nursing home residents or those enrolled in an HMO. There is also not charge for birth control prescriptions. (Regulation, effective 12/1/89)

ELIGIBILITY

MCH: Expands income eligibility for comprehensive medical care for pregnant women and infants whose family incomes are below 185% of the federal poverty level and, subject to budget limitations, for children under the age of 2 whose family incomes are below 100% of the FPL. The state may also increase income eligibility to children between the ages of 3 and 7 (inclusive) whose family incomes do not exceed 100% of the FPL, depending on the availability of state and federal funds. (SB 794, Chapter 614, 1989 Laws, effective 6/1/89)

Prescription Drugs: As a condition of participation participants in Maryland's Pharmacy Assistance Program may be required to apply for eligibility for the Medicaid program within 60 days of notification by the Department of Medical Assistance. (HB 815, Chapter 440, 1989 Laws, effective 7/1/89)

REIMBURSEMENT

Prescription Drugs: Unless a physician specifies that a prescription drug is "brand medically necessary", the reimbursement rate for prescription drugs for the Pharmaceutical Assistance Program will be the same as the reimbursement level under Medicaid for the generic equivalent (HB 815, Chapter 440, 1989 Laws, effective 7/1/89)

ADMINISTRATION & MANAGEMENT

Durable Medical Equipment: Increases time period for review of durable medical prices from two to three years. (HB 836, Chapter 462, effective 7/1/89)

Nursing Homes/Compliance/Sanctions: Allows that a civil money penalty may be imposed when there is clear and convincing evidence of an ongoing pattern of serious or life threatening deficiencies in a nursing facility. Penalties may be for up to $5000 per day up to a total of $50,000. Provisions for notification to the nursing facility, inspection and for rights to appeal and a hearing. The state must adopt regulations to implement this statue by October 1, 1989. (SB 448, Chapter 134, 1989 Laws)

Prescription Drugs/MCCA: Urges the President and the U.S. Congress to reconsider and amend the Medicare Catastrophic Coverage Act of 1988 to more evenly spread the costs of the insurance program among taxpayers and to control the costs of prescription drugs. (HJR 18, adopted 4/10/89)

Primary Preventive Care/Cost Containment: Directs the department to: (1) promote education for Medicaid recipients concerning preventive health care, good health habits and the value of developing ongoing relationships with primary care and other lower cost providers; (2) provide a comprehensive system of quality health care with an emphasis on prevention, education, individualized care and appropriate case management; (3) develop and encourage utilization of a prenatal care program for program recipients; (4) allocate resources to provide a balanced system of care; (5) seek to coordinate program activities with other state programs and initiatives; (6) promote program policies that facilitate access and continuity of care by developing cost-effective and appropriate alternatives to the current service delivery system; and (7) provide regular review of the program's regulations to asses administrative burdens.

Cost-containment features include: (1) working with representatives of inpatient institutions, third party payers and state agencies to control costs; (2) identifying and developing the optimal mix of state, federal and private resources to finance health care within the available resources; (3) developing joint legislative strategies to persuade the federal government to reconsider policies that discourage delivery of cost-effective care; and (4) aggressively pursuing third party recoveries. The law also urges health care providers to participate in the program and directs the department to seek the provision of appropriate levels of reimbursement to encourage participation. (SB 794, Chapter 614, 1989 Laws, effective 6/1/89)

OTHER MEDICAID RELATED STRATEGIES

No Changes

INDIGENT CARE & UNINSURED PROGRAMS

No Changes

MASSACHUSETTS

Please note that while legislative activity for the Medicaid program was limited, the Department of Public Welfare made a number of changes through regulations. These are indicated by "TL" (Transmittal Letter) along with the effective date. Laws are indicated as usual, with "HB" or "SB".

BENEFITS & COVERAGE

Dental Care: Removes limitations placed on administering general/intravenous anesthesia in the dentist's office. The provider must possess both an anesthesia-administration permit and an anesthesia-facility permit issued by the Massachusetts Board of Registration in Dentistry. (TL DEN-23, effective 3/27/89)

EPSDT: The following changes have been made to EPSDT medical protocol: (1) the 20-month age level has been changed to 18 months to coincide with the immunization schedule; (2) the periodicity for cholesterol and sickle cell tests has been moved up to earlier ages; (3) a test for chlamydia has been added; and (4) dental/fluoride assessment has been added. (TL FPA-14, effective 10/1/89)

LTC/Personal Needs Allowance: Allows Medicaid recipients in long-term care facilities to retain $72.80 per month as their personal needs allowance. (LTC Bulletin 6, effective 7/1/89)

Transition-to-Work: Authorizes the Department of Public Welfare (DPW) in accordance with federal regulation to extend certain primary and supplementary medical care and assistance to those families and individuals who lose Medicaid eligibility because of increased income from employment. (HB 5601, Chapter 240, 1989 Laws, effective 7/1/89)

ELIGIBILITY

Expands the presumptive eligibility program to enable any Medicaid provider who provides ambulatory prenatal care to make the presumptively eligibility determination. (Previously, the DPW authorized only certain community health centers to make such determinations.) A presumptively eligible woman will receive a temporary Medicaid identification card as proof of eligibility for ambulatory prenatal care for the dates specified on the card. (TL ALL-24, effective 8/1/89)

MASSACHUSETTS CONTINUED

REIMBURSEMENT

Clinical Labs: Requires the DPW to establish by regulation a payment methodology for clinical laboratory services to publicly assisted individuals based exclusively on a fixed, uniform fee schedule that sets forth rates of payment for all clinical laboratory services rendered by independent clinical laboratories. For FY 1990, the rates will be set at a level such that the average payment per test is approximately 95% of the average actual payment expended per test during FY 1989. (HB 6126, Chapter 287, 1989 Laws, effective 10/1/89)

FEE INCREASES: The Rate Setting Commission increased fees for the following services:

Children with Special **Needs:**

1. Reimbursement rates for home assessment are increased by 3.85% and TEAM meeting services provided by a social worker for children with special needs are increased by 5.86% respectively. TEAM meeting services include a review of an evaluation by a multidisciplinary team that consists of assessments in all areas related to the child's suspected need for special education and services. (TL 766-12, effective 7/1/89)

2. Reimbursement rates for medical and social services provided under the Early Intervention Program for potential or actual developmentally disabled children age three or under are increased by varying rates according to the service provided. (EIP-8, effective 7/1/89)

Chiropractors: Comprehensive manipulation/adjustment are increased to reflect change in Medicare rate; radiology services conducted by the chiropractor in the office are increased 4.4%. (TL CRP-13, effective 4/1/89)

Rehabilitation: Day Habilitation Services are increased 4.2%. (TL DHP-10, effective 7/1/89)

Substance Abuse: Drug Treatment Program Services are increased by 4%. (TL DTP-6, effective 7/1/89)

EPSDT: Fee is now set at 1.05 times the Community Health Clinic's (CHC) rate. (TL CHC-30, effective 7/1/89)

Hearing Aids: Fees are increased by 4.2% for: (1) dispensing fees for earmolds and ear impressions; (2) fees for minor repairs; and (3) maximum markup for major repairs. (TL HAD-7, effective 5/1/89)

Home Health: Private duty nursing services provided in the home are increased by 6.67%. (TL HHA-19, effective 9/1/89)

MASSACHUSETTS CONTINUED

Medical Equipment: Rate for technical labor required to fabricate or repair orthotic and prosthetic devices has been increased to $38/hr; professional labor required to fit devices is increased to $50/hr. (TL ORT-6 and TL PRT-6, effective 10/1/89)

Oxygen & Respiratory Therapy Services: Rates are increased by 4.2% (TL OXY-IO, effective 10/1/89)

Podiatrists: Fees were increased by 4.36%. (TL POD-14, effective 6/1/89)

Mental Health/Psychiatric and Psychology Services:

1. Day Treatment: Received a 7.8% increase in rates. (TL PDT-12, effective 7/1/89)

2. Therapist Rates: Hourly rate increases from $34.10/hr to $50.70/hr (TL THP-10, effective 5/1/89)

3. Psychological Testing Services: Fees increased from $32 to $38. (TL 766-11, effective 5/1/89)

Renal Dialysis: Fees are adjusted to the HCFA rate increase of 3%; added to designated services, effective 1 1/1/89.

Nursing Homes:

AIDS: Allows payment for specialized nursing units (SNUs) to care for patients with AIDS or ARC. Reimbursement for SNUs will be on a prospective payment system ("case-mix") basis, with 11 rather than the customary 10 categories. The 11 th category has been designed to compensate for patients who require an intense level of skilled nursing care. The nursing component of these rates will be derived from 150% of the mean nursing costs for the health services region within which the facility is located. In addition, certain costs such as those attributed to psychiatric nursing, infection control, and social services support staff, have been excluded from the variable cost ceiling and will have a test of reasonableness applied to them. (TL NH-13, effective 11/89)

Hospice Care: Changes rates for hospice room and board in SNFs and ICFs. Reimbursement will now be based on the county in which the nursing home is located. (TL HOS-4, effective 8/1/89)

Speech & Hearing: Rate Setting Commission has added two new service codes for out--of-office audiological and hearing aid evaluations. The first is for an evaluation for one recipient that exceeds two hours (the recipient must receive prior authorization for this service); and the second is a service code for each additional recipient that requires evaluations over two hours. (TL SHC-8, effective 2/89)

MASSACHUSETTS CONTINUED

ADMINISTRATION & MANAGEMENT

MCH: The DPW will transfer to the Department of Public Health through an interagency agreement $200,000 for outreach activities targeted for pregnant women. (Chapter 240, 1989 Laws, effective 7/1/89)

Nursing Home/Preadmission Screening: Incorporates preadmission screening requirements mandated under OBRA '87. (TL NH-1 1, effective 5/89)

Private Dutv Nurses: Establishes guidelines for initial and periodic screening for private duty nursing services. Also requires that providers receive prior authorization from the DPW or its screening agent regarding the frequency, duration and intensity of care before providing the services. (TL PDN-13, effective 2/17/89)

Recover-v: Makes retroactive rate adjustments revision in the method of repayment by a provider in the recovery of monies by the Department. Revision increases the amount of money the Department can deduct from monthly payments to a provider from 15% to 25%. (TL NH-8, effective 2/17/89)

Rehabilitation Facilities: Department now requires that rehabilitation facilities be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) as a condition of participation in the Medicaid program. Current providers are allowed a one-year period to achieve CARF accreditation; verification must be received by November 1, 1990. (TL RHB-9, effective 1 1/1/89)

Transportation: Implements changes in the provision of nonemergency transportation services. The traditional fee-for-service delivery system will be replaced by a transportation management brokerage program only in those areas that utilize selective contracting. The first such brokerage contract was enacted with the Worcester Regional Transit Authority (RTA) on October 1, 1989. That RTA will serve as the broker for recipients of the Worcester area local welfare office in all of the cities and town serviced by that office. Recipients must have rides coordinated by the RTA. RTA has accepted bids from transportation providers to provide services as subcontractors to the RTA. The DPW will reimburse designated services only through the Worcester RTA brokerage. The DPW is currently developing other contracts throughout the state. (Transportation Bulletin 11, effective 10/1/89)

OTHER MEDICAID RELATED STRATEGIES

LTC Studv/Trust Fund: Directs the DPW to study the feasibility of creating a long-term care trust fund as a supplement or as an alternative to the long-term care Medicaid program currently in effect, The Trust Fund, jointly funded by subscriber contributions and state appropriations, would provide non means-tested, time limited, long-term care health insurance coverage to all Massachusetts citizens who: (1) have contributed to the fund; (2) are over 65 years of age; (3) are in need of long-term care

services, whether institutional or home-based; and (4) receive services from qualified providers. The study will include the following: (1) findings, and if applicable, a recommended set of terms and conditions for operating the program; (2) a list of statutory or regulatory obstacles to implementing such a program at both the federal and state level; (3) an actuarially sound financial analysis which projects the levels of state appropriations and subscriber contributions necessary for successful operation of the program; and (4) a recommended series of steps needed to implement such a program. A report is due to the Legislature by 2/1/90. (HB 5601, Chapter 240, 1989 Laws, effective 7/1/89)

INDIGENT CARE & UNINSURED PROGRAMS

Nursing Homes/SSI Benefits: Increases monthly SSI benefits for level-IV residents in nursing home residents by $14. (LTC Bulletin 12, 1/89)

MICHIGAN

NOTE: Unless otherwise noted, the following abstracts were passed as part of Michigan's appropriations law: HB 4054, Public Act 200, Chapter 531, 1989 Laws, effective 10/1/89

BENEFITS & COVERAGE

No Changes

ELIGIBILITY

Rehabilitation/Medically Needy: The cost of remedial services incurred by residents of adult foster care and licensed homes for the aged shall be used in determining financial eligibility for the medically needy population. Remedial services is defined in this law as those services which produce the maximum reduction of physical and mental limitations and restoration of an individual to his or her best possible functional level. At a minimum, remedial services include basic self-care and rehabilitation training for a resident.

REIMBURSEMENT

DRG Adjustments: Directs the legislature to annually adjust the inpatient DRG prices and per diem for inflation. Adjustment may be based on a number of estimated inflation indices, included the Medicare update factor for operating prices and input from the DSS and affected providers. Sets the adjusted DRG price and per diem update for 4/1/90 at 2.0%

Home Health Agencies: Free-standing, non-governmental home health care agencies that treat medicaid patients may now be reimbursed for mileage associated with a Medicaid visit at a rate of 24 cents per mile for all mileage in excess of 10 miles per visit.

Hospitals/Outpatient Services:

Fee Screens: Directs the legislature to annually adjust for inflation fee screens for outpatient hospital services; the fee screen adjustment for 4/1/90 is set at 2.0%.

Outpatient Surgery: Directs the DSS to establish an all-inclusive facility rate reimbursement for selected surgeries performed in outpatient hospital setting.

Reimbursement will be set at the lesser of a) the all-inclusive facility rate or b) charges.

Medicare Buy-In: Sets reimbursement level for Medicaid buy-in under Medicare Catastrophic Coverage Act of 1988 at Medicaid-only reimbursement levels. Payment must be accepted as payment in full; no payment except an approved Medicaid copayment may be billed to a client.

Nursing Homes; The legislatively mandated inflation factor applied to increased rates for nursing homes and chronic care units and county medical care facilities shall be 4% (effective 10/1/89). It is the intent of the legislature that at least 50% of this aggregate increase in rates be used for wage and benefit pass-through to direct patient care staff, based upon a plan developed by the DSS. The rate increase for enhanced wages and benefits shall be provided to applying facilities to fund the Medicaid program share of wage and benefit increases up to $.50 per employee hour. Facilities are required to document that these wage and benefit increases were actually provided.

Prescription Drugs/Pharmaceuticals: Sets pharmaceutical dispensing fee at a maximum of $3.72 (effective 4/1/90); DSS is prohibited from changing coverage or reimbursement of pharmaceutical products as described in the state Medicaid plan without explicit approval of the senate and house appropriations subcommittees on social services.

Providers/Access: Increases rates for dentists, physicians and home health agencies to improve access of Medicaid clients to these health care services. (effective 4/1/90)

ADMINISTRATION & MANAGEMENT

Cost-Containment: To obtain the Medicaid cost reduction provided for in the appropriations law, the DSS will do the following:

HMO: Assign Medicaid clients in certain counties who do not choose a managed care provider to an HMO or a capitated ambulatory plan provider; the DSS may pay a provider which is selected to receive these enrollments at a rate less than 90% of the fee-for-service equivalent rate; and

Hospital DRG: Revise the Medicaid inpatient hospital DRG and per diem prices for dates of service between 2/1/85 and 3/31/87 to correct for overpayment; recoveries will be accounted as a receivable beginning 10/1/89;

LTC Providers: Eliminate the “grandfather” clause related to capital reimbursement for long-term care providers; as of 10/1/89 all providers will be reimbursed under the new tenure factor methodology;

Psychiatric Inpatient Services: Increase controls on psychiatric admissions and continued inpatient stays by implementing a telephone authorization and certification program. The programs shall include approval of all inpatient admissions and periodic review based on projected length of stay. This review program shall be added to the existing hospital utilization review contract;

Third Party Liability: Continue to work with Blue Cross and other commercial insurers to increase third party liability savings. The DSS must submit quarterly reports to the senate and house appropriations subcommittees on social services the progress being made by the department to implement and produce savings that result from these strategies.

Hospitals/Prior Authorization: Directs the state to expand inpatient hospital prior authorization and on-site review system.

MCCA Implementation: Increased Assistance payments staff (+14.0 FTEs) and County Clerical Support Staff (5.2 FTEs) to implement the Medicare Catastrophic Coverage Act of 1988. Increased funding to cover increased amount which can be retained by the spouse of an institutionalized person.

Organ Transplants: Eliminated the remaining funding for the University of Michigan Transplant Policy Center.

Staffing: Increases Assistance Payments workers to obtain more acceptable case-to-worker ratios.

OTHER MEDICAID RELATED STRATEGIES

AIDS Insurance/Pilot Project: As a result of legislation enacted in 1988 (Act 322, 1988), the state developed and implemented a two-year pilot program in three counties to assist individuals with AIDS or AIDS related diseases with insurance who would become Medicaid eligible. Targeted individuals must: (1) presently have health insurance; (2) have incomes are below 200% of poverty; (3) have assets below $10,000; and (4) have documentation that they are at risk of losing their health insurance because of AIDS related diseases. The program, implemented in October of 1989, is expected to enroll approximately 200 individuals and anticipates a potential savings of approximately $3.6 million in 1990. These figures are expected to increase to 340 enrollees and $6 million in savings in **1991.** The program is financed with state-only funds.

Psycholoaical Services for Children/Study: Directs the DSS to study feasibility of covering psychological services for acutely and chronically ill, abused, neglected, and delinquent children and their families in the Medicaid program. Based upon this evaluation, the DSS may expand Medicaid coverage of these services on or after

4/1/90 if no additional state general fund costs for these services are projected and if appropriate utilization controls are implemented.

INDIGENT CARE & UNINSURED PROGRAMS

Dental Care: Limits program allocation for contract with dental schools for the provision of dental care to uninsured indigent population to $300,000.

Liability Insurance: Makes available up to $8,000 to pay the cost of medical liability insurance for those professionals who participate in the uncompensated health care project of the Wayne county and Detroit medical societies.

Mental Health: Authorizes DSS, in cooperation with the Department of Mental Health, to enter into a contract in counties with a population exceeding 1.5 million to provide transportation to publicly operated or contracted mental health facilities. The total costs of the contract may not exceed $200,000.

Personal Care Services under SSI: Payment levels for personal care services for eligible SSI recipients in supervised living is $110.70 as of 4/1/90.

Personal Needs Allowance for SSI: PNA for SSI beneficiaries living in adult foster care homes of homes for the aged is increased from $36 to $40 as of 4/1/90.

Substance Abuse Reimbursement for GA Recipients: Appropriates $1.5 million to increase room and board rates for substance abuse services to general assistance recipients. Under the new law, providers will now be reimbursed at the equivalent of the domiciliary care rate.

MINNESOTA

BENEFITS & COVERAGE

No Changes

ELIGIBILITY

MCH: Extends eligibility to children up to age 7 with family incomes at or below 100% of poverty. (HB 1759, Chapter 282, 1989 Laws, effective 7/89)

Spousal Impoverishment: Incorporates the revised income and asset rules established by the MCCA of 1988, for a couple when one spouse is institutionalized and seeking Medicaid eligibility. Adopts federal minimum of $12,000 for community spouse resource limit. (HB 1759, Chapter 282, 1989 Laws, effective 10/89)

Transfer of Assets: Adopts federal requirement that Medicaid applicants who have transferred their assets for less than fair market value within 30 months of the time of application will be ineligible for nursing home services under Medicaid for up to 24 months. (HB 1759, Chapter 282, 1989 Laws, effective 7/89)

REIMBURSEMENT

Hospitals: (HB 1759, Chapter 282, 1989 Laws, effective 7/89)

Certified Registered Nurse Anesthetists: As of January 1, 1991, hospitals will be allowed to exclude the cost of certified registered nurse anesthetist from the operating payment rate. To be eligible, a hospital must notify the commissioner in writing by October 1 of the year preceding the rate year of the request. The hospital must agree that all hospital claims for the cost and charges of registered nurse anesthetists services will not be included as part of the rates for inpatient services provided during the rate year.

DSH: Brings state statutes regarding the Medicaid disproportionate share adjustment into compliance with federal law for admissions to disproportionate share hospitals on or after 7/1/89. For admissions occurring on or after 1/1/91, the adjustment will be derived from the base year Medicare cost report data and may be adjusted by data reflecting actual claims paid by the department.

Rate-Setting: Revises the authority for setting hospital reimbursement under the Medicaid program now that a state DRG system, with adequate data bases, is firmly established. Hospitals with fewer than 30 annualized Medicaid admissions, excluding the Medicare crossover admissions, may have the base year operating rates, adjusted by case mix and property payment rates established at the 70th percentile of peer group hospitals in effect when the base year is established. Requires the Commissioner to establish day and cost outlier thresholds for each diagnostic category. Payment for days and costs beyond the thresholds will be in addition to the operating and property payment rates per admission established in this law. Payment for outliers will be at 70%, or a variable percent as determined by the hospital, of allowable operating costs after adjustments. Specifies appeals procedures. Allows the Commissioner to establish special rate-setting methodologies for hospice, ventilator dependent, and other hospital services on a hospital and recipient specific basis. Hospice rates may not exceed the amount allowed under federal law and payment will be secondary to any other medical assistance hospice program.

ICF/MR: Directs the Department of Health to establish reimbursement classifications for each client in an ICF/MR based on assessment and according to rules established by the Department of Human Services (DHS). Establishes procedures for notification of the client and the facility and request for reconsideration. (HB 1759, Chapter 282, 1989 Laws, effective 7/89)

Medicare Buy-in: Brings state statutes into compliance with the MCCA; requires Medicaid to pay the cost sharing requirements of Medicare eligibles using the federally mandated phased-in schedule: those with incomes at or below 85% of poverty as of 7/89; 90% of poverty as of 1/90; 95% of poverty as of 1/91; and 100% of poverty as of 1/92. (HB 1759, Chapter 282, 1989 Laws, effective 7/89)

Nursing Homes: Revises reimbursement system for paying hospital-attached nursing homes. Also makes numerous revisions to the treatment of operating and property-related costs in reimbursing nursing homes. (HB 1759, Chapter 282, 1989 Laws, effective 7/89)

ADMINISTRATION & MANAGEMENT

AIDS: Requires nursing homes to accept persons infected with the HIV or the hepatitis B virus, unless the facility cannot provide appropriate care. (HB 1759, Chapter 282, 1989 Laws, effective 7/89)

Hospitals/Study: Requires a study to evaluate inpatient and outpatient hospital payment systems. Study will include recommendations concerning: (I) more effective methods of assigning operating and property payment rates to specific services or diagnoses; (2) effective methods of cost control and containment; (3) fiscal impacts of alternative payment systems; (4) the relationship between utilization and payment for inpatient and outpatient hospital services; (5) methods to relate reimbursement levels

to efficient provision of services; and (6) methods to adjust reimbursement levels to reflect cost differences among geographic areas. The report must be submitted to the legislature by 1/91. (HB 1759, Chapter 282, 1989 Laws, effective 7/89)

Nursing Homes:

Patient Rights: Requires nursing homes to educate potential residents and residents of the content of the admission contract, and that the admission contract contain provisions protecting the interests of the resident. (HB 1423, Chapter 285, 1989 Laws, effective 7/89)

Staffing Requirements: Requires certified nursing homes to provide the following level of nursing care: the greater of two hours per resident per 24 hours or 0.95 hours per standardized resident day. (HB 1759, Chapter 282, 1989 Laws, effective 7/89)

OTHER MEDICAID RELATED STRATEGIES

ICF/MR: Authorizes the DHS to conduct experimental projects to determine the effects of competency-based wage adjustments for direct-care staff on the quality of care and active treatment for persons with mental retardation or related conditions. (HB 1759, Chapter 282, 1989 Laws, effective 7/89)

MCH/Infant Mortality: Directs the DHS to undertake a statewide media campaign promoting early prenatal care. (HB 1759, Chapter 282, 1989 Laws, effective 7/89)

INDIGENT CARE & UNINSURED PROGRAMS

Children/Mental Health: Adds to the Children's Health Plan coverage of children ages 9-18 (effective 1/1/90) and coverage of mental health services (effective 7/1/90). The Children's Health Plan was established in 1988 and provides ambulatory health care to children whose family income is at or below 185% of the federal poverty level. (HB 1759, Chapter 282, 1989 Laws, effective 8/89)

MISSISSIPPI

BENEFITS & COVERAGE

Adoption/Special Needs Children: Authorizes the Department of Public Welfare (DPW) to enter into interstate agreements with agencies of other states for protection of children on behalf of whom adoption assistance is being provided and to provide adoption assistance payments, including medical payments. A child with special needs who is a Mississippi resident and who is the subject of an adoption assistance agreement with another state and who has been determined to be eligible for Medicaid in that state shall be entitled to receive a medical assistance identification card from Mississippi upon filing a certified copy of the adoption assistance agreement with the DPW. In order for the child to receive medical assistance, the adoptive parents must show at least annually that the adoption agreement is still in effect or has been renewed. The Division of Medicaid (DOM) is responsible for processing the claim and making payment. Fraudulent claims are punishable by a maximum fine of $10,000 or up to 2 years imprisonment or both. (HB 460, Chapter 401, 1989 Laws, effective 7/1/89)

Disabled:

Attendant Care Services: Exempts attendant care services that are delivered by the Independent Living Center (ILC) and funded through a cooperative agreement with the DOM from the requirements under the attendant care program sponsored by the ILC under the Division of Vocational Rehabilitation. These include requirements that 80% of the disabled be quadriplegic and 50% of the population served be employable or seeking employment. (SB 2312, Chapter 579, 1989 Laws, effective 7/1/89)

Handicapped Students: Directs the Department of Education (DOE) to match minimum program funds allocated for services to handicapped children with DOM funds to provide language-speech services, physical therapy and occupational therapy to handicapped students who meet DOE or DOM standards and are Medicaid eligible. (SB 2467, Chapter 580, 1989 Laws, effective 7/1/89)

Inpatient Hospital Services: Sets a limit on the number of inpatient hospital days for Medicaid beneficiaries. The Division of Medicaid may allow up to 30 days of inpatient hospital care annually for all Medicaid recipients; however, before any recipient will be allowed more than 15 days in any given year, that client must obtain prior approval from the division. The division is also authorized to allow unlimited days to disproportionate share hospitals for eligible infants under the age of 1 year. (HB 728, Chapter 527, 1989 Laws, effective 7/1/89)

MISSISSIPPI CONTINUED

Insurance Renulations: Prohibits insurance policies from excluding individuals or groups from coverage because they are eligible for or receiving assistance under Medicaid. (HB 1005, Chapter 408, 1989 Laws, effective 7/1/89)

Prescription Drugs: Under the new law, DOM now allows 5 prescriptions per month for noninstitutionalized Medicaid recipients. (HB 728, Chapter 527, 1989 Laws, effective 7/1/89)

ELIGIBILITY

MCH: Extends coverage to children under five years whose family income does not exceed 100% of the FPL (HB 728, Chapter 527, 1989 Laws, effective 7/1/89).

QMBs: Extends coverage to Qualified Medicare Beneficiaries whose resources do not exceed 200% of the amount allowed under SSI and whose income does not exceed the federal poverty level on the phase-in schedule mandated by the Medicare Catastrophic Coverage Act of 1988--85% of the FPL on 1/1/89; 90% of the FPL on 1/1//90; 95% on 1/1/91; and 100% on 1/1/92. (HB 728, Chapter 527, 1989 Laws, effective 7/1/89).

REIMBURSEMENT

Physician Services: Increases reimbursement for initial office visits to $22 and $15 for a follow-up visit. Reimbursement rates for inpatient hospital visits are increased to $23 for the initial visit and $10 for a follow-up visit. Other fees for physicians' services will be paid in the amount as provided under the division's fee schedule. (HB 728, Chapter 527, 1989 Laws, effective 7/1/89).

Prescription Drugs: Payment for covered multiple source prescription drugs will be limited to the lower of: (1) the upper limits established and published by HCFA plus a $3.75 dispensing fee; or (2) the estimated acquisition cost (EAC) as determined by the division plus a $3.75 dispensing fee; or (3) the providers' usual and customary charge to the general public. (HB 728, Chapter 527, 1989 Laws, effective 7/1/89).

ADMINISTRATION & MANAGEMENT

Statute Repeal Provision: If state appropriations for functions provided under Chapter 527 exceed $135.4 million (increased from $130 million), the Article will be repealed (see HB 728 abstracts under Benefits, Eligibility and Reimbursement). (HB 728, Chapter 527, 1989 Laws, effective 7/1/89).

MISSISSIPPI CONTINUED

OTHER MEDICAID RELATED STRATEGIES

No Changes

INDIGENT CARE & UNINSURED PROGRAMS

County Health Foundations: The Mississippi Legislature authorized the establishment of three county health foundation funds to support health care services for indigent or needy county residents. The Union County and Oxford/Lafayette County Foundations will be funded through lease payments by the county hospitals (the payments represent payments made in consideration of the hospitals' net current assets); 15% of the fund will be retired as principal and the remaining 85% will be used for purposes outlined in the legislation below. The Quitman County Fund may receive payments from any available county funds, including lease payments by the county hospital.

Oxford/Lafayette County Community Health Foundation: Authorizes the Mayor and Board of Aldermen in the City of Oxford and the Lafayette County Board of Supervisors to establish and operate the Oxford/Lafayette County Community Health Foundation Fund. Establishes a nine-member Board of Trustees to administer the Foundation. Funds will be used to pay for uncompensated hospital care (both inpatient and outpatient) received by the county's indigent or needy patients and to administer the fund. (HB 1476, Chapter 849, 1989 Laws, effective 6/5/89)

Quitman County Indigent Care and Health and Welfare Fund: Authorizes the County Board of Supervisors to make annual payments to the indigent care fund from any available county source, not to exceed a total of $110,000. The first annual payment will be made on or before 4/15/90, following the effective date of the lease for the Quitman County Hospital and Nursing Home, Inc. The Board of Supervisors will appoint a five-member Board of Trustees to administer the Fund, which will provide health care treatment to county indigent and needy patients, and reimburse the county hospital for uncompensated care costs. (SB 3093, Chapter 894, 1989 Laws, effective 6/17/89)

Union County Health Foundation and Fund: Authorizes Union County to create and administer the Union County Health Foundation and Fund to provide medical assistance to indigent county residents. Establishes a five-member Board of Trustees to administer the Foundation. Money from the Fund will be used for the following purposes: (1) support administration of the Foundation; (2) pay or defray hospital uncompensated care costs of indigent or needy residents; (3) provide loan or grant scholarships for educational assistance to hospital employees or students who, in return for the assistance, will agree to work at the hospital for a stipulated period of time; (4) promote cost-containment efforts; (5) recruit and financially assist physicians and other practitioners to locate in underserved areas; (6) expand community-based health services; (7) pay any contingent liability of Union County General Hospital; (8)

subsidize losses from operation of the hospital's ambulance service; and (9) to defray expenses of hospital employees who attend professional meetings. (HB 1443, Chapter 832, 1989 Laws, effective 6/5/89)

MISSOURI

BENEFITS & COVERAGE

Hospice/Optimal Services: Added coverage of hospice services as an optional service under Medicaid. (HB 1139, 1989 Laws, effective 5/15/89)

Transition-to-Work: Any family receiving aid under AFDC in at least three of the six months immediately preceding the month in which the family becomes ineligible because of employment will continue to be eligible for medical assistance for six months as long as the family includes a dependent child. Each family that has received such medical assistance during the entire six month period and that meets reporting requirement and income tests under AFDC will receive medical assistance without fee for an additional six months. The Division of Medical Services may provide by rule the scope of medical assistance coverage to be granted to such families. (HB 2-X, 1989 Laws, effective 4/1/90)

ELIGIBILITY

Soousal Impoverishment:

Income: For noninstitutionalized individuals or individuals not in Medicaid certified nursing facilities, the income of both members of the couple are used to determine eligibility. The income, after allowable deductions, is compared to the SSI maximum. Income over the SSI maximum is used to determine the amount of "spenddown". For institutionalized individuals, only the income of the institutionalized person is used to determine the amount s/he must pay to the nursing facility. Institutionalized claimants may make allotments of their income (and thereby reduce the amount that must be paid to the nursing facility) to the community spouse and certain other dependents who reside with the community spouse.

Resources: In determining eligibility for Medicaid, the homestead is exempted as a resource. An individual's countable resources must be less than $1,000 and a couple's resources cannot exceed $2,000 in order to qualify for Medicaid. A $1,500 face value exemption is allowed for any combination of life insurance and rearranged burial contracts for each member of a couple. The $1,500 exemption is first applied to prearranged burial contracts. If there is a remainder of the exemption, it is applied to life insurance policies with the greatest cash surrender value. For individuals institutionalized in Medicaid certified nursing facilities on or after September 30, 1989 with a spouse in the community, one half of the couple's assets (with a $12,000 minimum and $60,000 maximum) are considered protected for the community spouse.

MISSOURI CONTINUED

Transfer of Assets: For transfers which occur on or after July 1, 1989, only eligibility for nursing facility services or home and community-based services are affected. Claimants may receive General Medical and Surgical Medicaid benefits even if they transfer assets without receiving fair and valuable consideration. The uncompensated value of the transferred resource is divided by the statewide average for a private pay patient in a nursing facility (currently $1725 per month). The result is the number of months of ineligibility, not to exceed 30 months from the date of the transfer. (SB 203 and 270, 1989 Laws, effective 7/1/89)

REIMBURSEMENT

Nurse Anesthetists: Recognizes certified registered nurse anesthetists (CRNA) as independent providers to receive direct reimbursement. (OBRA '86, effective 7/89)

OMB: Requires the State to pay Medicare premiums for eligible QMB's and reimburse copayments and deductibles for Medicaid-enrolled and non-enrolled providers under Supplemental Medical Insurance (SMI) of beneficiaries who are dually eligible for Medicaid and Medicare Part B (SB 203 and 270, 1989 Laws, effective 7/1/89).

ADMINISTRATION & MANAGEMENT

Nursing Home Reform:

Compliance/Sanctions: Authorizes civil penalties for violation of state or certain federal nursing home care standards. At the request of the Department of Social Services (DDS), the Attorney General may file suit to recover the penalties. The total amount of civil penalties imposed for all such violations may not exceed $10,000 per day. The amount of the civil penalty for a particular violation will be determined by the circuit court within the limits established for each class of violation. A civil penalty may be doubled if a specific violation has been previously cited within a certain time period. Recovered penalties will be deposited in the general revenue fund. A violation is defined as a breach of a federal or state requirement which, upon reinspection, is not being corrected in accordance with an approved plan. The civil penalty will be assessed for each day from the time the violation is cited until it is corrected. However, the penalty will not be assessed for a period when a facility is making a good faith effort to remedy the violation. Civil penalties are also established for falsifying a resident's assessment.

Recovery: Recovery of civil penalties under this law will be based upon clear, cogent and convincing evidence of the violation. Directs the DSS to maintain a registry of those individuals found to have misappropriated a nursing home resident's property or funds. A nursing home or in-home care provider may not employ such individuals in direct client care and will not be liable for firing or not hiring them. Law provides

appeal, investigation and hearing procedures. (SB 203 and 270, 1989 Laws, effective 7/1/89)

OTHER MEDICAID RELATED STRATEGIES

AIDS CBS Waiver Program: The AIDS Home and Community Based Waiver Program provides home-based treatment to eligible recipients with AIDS or disabling ARC who would otherwise require hospitalization. The waiver program became operational July 1, 1989; first year projections estimate that service will be provided to a maximum of 298 recipients. Services include: (1) waiver attendant care; (2) private duty nursing; (3) supplies such as gloves, diapers and underpads--items that are not available under the state plan program; and (4) non-emergency transportation.

Psychiatric Rehabilitation: Targets psychiatric rehabilitation services to those individual who are found through assessment to be seriously and persistently mentally ill for the purpose of maintaining these individuals in a community setting. Services may only be provided by providers meeting Department of Mental Health (DMH) certification requirements. Recipients must be Medicaid eligible in addition to meeting program eligibility criteria as determined by DMH; participation is limited to those with a specific diagnosis and functional impairment in the area of social role functions. Services include evaluation and assessment, crisis intervention, intensive and non-intensive community support, psychosocial rehabilitation, and medication administration. (HB 1139, 1989 Laws)

Day Rehabilitation/Head Injury: Provides a program to serve persons with disabling impairments as the result of traumatic head injury. The program provides intensive, post-acute services designed to prevent and/or minimize chronic disabilities and restore the individuals to an optimal level of functioning. The program's emphasis is on functional living skills, adopting strategies for cognitive memory or perceptual deficits and appropriate interpersonal skills. Providers enrolled in this program must have space and staff dedicated to head injury rehabilitation and be CARF accredited. Services require prior authorization and include evaluation and assessment, therapy, counseling, education and vocational services. (HB 1139, 1989 Laws, effective 7/1/89)

Hospitals/Inpatient Admission Certification: Inpatient hospital admissions must be certified as medically necessary and appropriate for inpatient services prior to payment. Services for deliveries and newborns are exempt from this policy. (13 CSR 70-15.020, effective 11/1/89)

Nursine Homes/Preadmission Screening: All applicants to a Medicaid certified nursing home must be screened prior to admission to assure that mentally retarded developmentally disabled or acutely mentally ill persons who could benefit from active treatment are placed in an appropriate setting. The DSS and DMH have developed a uniform screening tool and procedure for this process (13 CRS 70-10.040, effective 1/1/89)

INDIGENT CARE & UNINSURED PROGRAMS

Deceased Indigents: Adds the option of cremating a deceased indigent and enables the coroner to dispose of the remains and obtain compensation for expenses and services related to the cremation. The remains must be placed in a marked grave. (HB 64, Chapter 58, 1989 Laws, effective 8/28/89)

MONTANA

BENEFITS & COVERAGE

Hospice: Adds hospice as a service under Medicaid. Service will be terminated as of 6/91. (HB 663, Chapter 633, 1989 Laws, effective 7/89)

Local Health: Adds health services provided under a physician's order by a public health department to the services covered by Medicaid (HB 524, Chapter 417, 1989 Laws, effective 7/89).

MCH:

Ambulatory Care: Adds ambulatory care for pregnant women during the period of presumptive eligibility (see eligibility below). (HB 773, Chapter 649, 1989 Laws, effective 7/1/89)

EPSDT/Psychiatric Services: Adds EPSDT and inpatient psychiatric services for children under 21 to state Medicaid program. (HB 452, Chapter 711, 1989 Laws, effective 10/1/89)

Providers/Physician Assistants: Certifies services provided by a physician assistant as allowable under Medicaid. (SB 26, Chapter 97, 1989 Laws, effective 10/89)

ELIGIBILITY

MCH:

Program Expansion: Revises Medicaid eligibility to include (1) pregnant women and infants with income at or below 100% of the federal poverty standard; (2) children under 21 in foster care who are wards of the state or were previously wards of the state and have been adopted as hard-to-place children; and (3) individuals under 19 years of age who qualify for AFDC. (HB 453, Chapter 310, 1989 Laws, effective 7/1/89)

Presumptive Eligibility: Adds presumptive eligibility for pregnant women with family incomes at or below 100% of poverty. (HB 773, Chapter 649, 1989 Laws, effective 7/1/89)

Transition-to-Work: Conforms state law to Family Support Act of 1988 that requires Medicaid to extend coverage for 12 months to families that become ineligible for cash assistance due to earnings. (SB 67, Chapter 453, 1989 Laws, effective 4/89)

MONTANA CONTINUED

REIMBURSEMENT

Medicare Buy-in: Requires Medicaid to pay for the cost sharing requirements of Medicare for eligible individuals below a certain income level. (HB 452, Chapter 711, 1989 Laws, effective 10/1/89)

OMB: Authorizes the state to pay copayments and deductibles for dually eligible beneficiaries for Medicare recipients whose income does not exceed federal income standards ($424/month) and whose resources do not exceed what the department has deemed reasonable for purposes of this program. (HB 453, Chapter 310, 1989 Laws, effective 7/1/89)

ADMINISTRATION & MANAGEMENT

Rule Making Grants Department of Social and Rehabilitation Services greater authority in the rule making of the Medicaid program to address: (1) services covered; (2) nature, amount duration and scope of services; (3) reimbursement rates; (4) interaction between department and providers; and (5) sanctions or actions against certain providers. (HB 452, Chapter 711, 1989 Laws, effective 10/1/89)

TPL/Liens: Establishes more stringent third party recovery action for medical assistance provided by the state or counties, primarily through the use of liens. (HB 204, Chapter 482, 1989 Laws, effective 4/89)

OTHER MEDICAID RELATED STRATEGIES

Demonstration/Pilot Projects:

MCH/Infant Mortality: Establishes prenatal care demonstration project and advisory council to: (1) reduce infant mortality and low birthweight; (2) improve access to prenatal care; (3) expand access to other public assistance and educational programs; (4) provide outreach and referral services; and (5) conduct a public education program on the importance and availability of prenatal care services for pregnant women and children. Coordinates project with existing programs, including EPSDT, Medicaid services for pregnant women, and the federal Maternal and Child Health Services Block Grant. (HB 773, Chapter 649, 1989 Laws, effective 7/89)

Psychiatric Residential Treatment Services: Establishes a two-year pilot project for Medicaid reimbursement of inpatient psychiatric services in a residential treatment facility; termination date is 7/91. (HB 304, Chapter 616, 1989 Laws, effective 7/89)

MONTANA CONTINUED

INDIGENT CARE & UNINSURED PROGRAMS

General Assistance:

Eligibility: Redefines eligibility for general relief medical assistance based on income and having a "serious medical condition." Serious medical condition is defined to include pregnancy. (SB 101, Chapter 580, 1989 Laws, effective 1/90)

Fraud **and Abuse:** Clarifies parts of the general relief medical assistance program, including that a household is ineligible for Medicaid due to overpayment, fraud or a refusal to comply with program requirements. (HB 723, Chapter 451, 1989 Laws, effective 7/89)

Transition-to-Work: Provides greater financial incentives for general relief recipients of obtain employment by increasing income eligibility limit for medical assistance if eligibility for general relief assistance is lost due to employment. (SB 134, Chapter 603, 1989 Laws, effective 7/1/89)

NEBRASKA

BENEFITS & COVERAGE

No changes

ELIGIBILITY

Spousal Impoverishment: Sets minimum community spouse income floor at the federal standard of $12,000. (LB 362, 1989 Laws, effective 10/1/89)

REIMBURSEMENT

Providers: Implemented fee schedule for all practitioners; effective 8/1/89.

ADMINISTRATION & MANAGEMENT

Disabled Children/Study: Directs the Appropriations Committee to conduct an interim study of the feasibility of using federal Medicaid funds to pay 60% of the cost of educationally related services for medicaid-eligible disabled children. The study will examine the following issues: (1) the funds currently allocated for educationally-related services to this population; (2) the methods and procedures established by other states to obtain medicaid funding for services to handicapped children; (3) the benefits and disadvantages of using federal funds for this purpose; and (5) the projected impact on the total array of services provided to handicapped children through medicaid. (LR 126, adopted 5/24/89)

OTHER MEDICAID RELATED STRATEGIES

No changes

INDIGENT CARE & UNINSURED PROGRAMS

Studies:

State Health Insurance (The CHIP Program): Directs the state Health and Human Services (HHS) Committee and the State Insurance Pool Banking, Commerce and Insurance Committee of the Legislature to conduct an interim study to examine issues

associated the Comprehensive Health Insurance Pool (CHIP) program. The study will include but not be limited to CHIP's financial status; cost-containment; current and projected utilization; rate setting methodology for CHIP premiums; current and alternative funding sources for the pool; eligibility for membership; management of the pool; and the need for change in federal laws, rules and regulations that adversely affect the program. Directs the committees to report findings to the Legislature or the Legislative Council. (LR 144, adopted 5/24/89)

Employer-Based Health Insurance: Directs the HHS Committee to conduct an interim study of: (1) the effectiveness of incentives for businesses to provide health insurance coverage for their employees; (2) the feasibility of establishing an employer-based insurance pool for the working uninsured; and (3) other related issues. (LR 159, adopted 5/24/89)

General Health Issues: Directs the HHS Committee to conduct an interim study of major health issues including but not limited to cost containment, AIDS, indigent care, maternal and infant care, the availability of nurses and other health providers, emergency services, long-term care, mental health, environmental health, and services for the aged, disabled and developmentally impaired. (LR 156, 1989 Laws, adopted 5/24/89)

NEVADA

BENEFITS & COVERAGE

No Changes

ELIGIBILITY

Spousal Impoverishment: Allows couples to divide community income, assets and obligations into equal but separate shares. The agreement is only effective if one of the spouses is admitted into a SNF or ICF, or if the division of resources would allow one of the spouses to become eligible for services under Medicaid. Such an agreement may not be binding on the welfare division of the department in making eligibility determinations for assistance to the medically indigent. (AB 270, Chapter 170, 1989 Laws, effective 10/1/89)

REIMBURSEMENT

No Changes

ADMINISTRATION & MANAGEMENT

Nursing. Homes:

Compliance/Sanctions: Allows the health division of the Department of Human Resources (DHR) to impose intermediate sanctions against medical facilities or nursing homes that are out of compliance with licensure requirements. These include: (1) prohibiting the facility from admitting any patient until the violation has been corrected; (2) limiting occupancy to the number of beds occupied when the violation occurred; (3) imposing and administrative penalty of not more than $1,000 per day for each violation, together with interest not to exceed a rate of 10% per annum; and (4) appointing a temporary manager to oversee the operation of the facility and ensure the health and safety of the patients.

Requires the DHR to adopt regulations establishing criteria for the imposition of sanctions, including: (1) prescribing the circumstances and manner in which each sanction applies; (2) minimizing the time between identification of a violation and the imposition of a sanction; (3) providing incrementally more severe sanctions for repeated or uncorrected violations; and (4) providing less severe sanctions for less severe violations. If an owner of a facility in violation wants to contest the action of

the DHR and files an appeal, the health division must hold a hearing within 30 days. (AB 601, Chapter 406, 1989 Laws, effective 10/1/89)

Fees: Increases licensing fee from $100 to $250 and increases licensure period from 1 to 2 years. (AB 667, Chapter 375, 1989 Laws, effective 10/1/89)

Nurse Aide Training: Defines "basic nursing services" as acts designated by the board which are within the practice of nursing under the direction of a RN or a LPN that do not require the substantial specialized skill, judgment and knowledge required of a licensed nurse. A nursing assistant is a person who functions under the direction of a licensed nurse in a medical facility and for compensation, performs basic restorative services and basic nursing services which are directed at the safety, comfort, personal hygiene, basic mental health and protection of patients and the protection of their rights. Authorizes the state board of nursing to adopt regulations to carry out the nurse assistant training requirements consistent with state and federal law. Will establish an advisory committee on nursing assistant, consisting of 10 appointed members to include representatives from facilities for long-term care, medical facilities for acute care, home care, state divisions of health, welfare, and aging services, aging consumer organization, a nursing assistant, RN and LPN.

Nurse assistant standards require that applicants for certification be of good moral character, in good physical and mental health, at least 16 years of age and meet other board-specified requirements. Applicants must not have committed acts that would be grounds for disciplinary action, unless sufficient restitution is determined to have been made. The state may certify by endorsement a nursing assistant from another jurisdiction if equal competency and evaluation standards have been met. Nevada's training program must consist of 75 hours of instruction and include no less than 60 hours of learning skills in a laboratory setting. The program must be completed within 3 months after the nursing assistant trainee beings employment. Nursing assistant already employed in medical facilities may continue to practice if they meet certain state-specified requirements and apply for certification with documentation of compliance before March 1, 1990.

Instructors for the program must be registered nurses with at least three years of direct care nursing experience as well as supervision and education of staff. LPNs may be designated as instructors at the board's discretion. Upon completion of the course, the trainee must pass a test in theory with an overall score of 80% and test of skills on a pass/fail basis. If the trainee fails either test, they must retake the training in the deficient areas before retaking the examination. In the case of a failed test, the trainee may only perform those tasks he has successfully completed in the training program.

Any medical facility, educational institution or other organization may provide a training program if the program meets the state requirements and is approved by the board. Authorizes the University of Nevada System, the board for occupational education or a public school to administer a nurse assistant certification program.

Expanded approval was enacted to allow a nursing assistant to be certified to perform designated acts in medical facilities which provide acute care in addition to basic nursing services if the nursing assistant has 1500 hours of experience, has completed an additional board-approved training program, and performs only designated acts.

Certification for nursing assistants must be renewed biennially. Requirements include additional training, no disciplinary actions, and documentation of employment as a nursing assistant during the two years preceding the renewal date. Failure to comply can result in forfeiture of the right to practice. Statute also specifies grounds for suspension of a certificate. Use of uncontrolled substances is grounds for disciplinary action. Requires that most licensed health professional report any unprofessional conduct of a nursing assistant to the board. (SB 85, Chapter 840, 1989 Laws)

Patient Rights: Requires the Governor to appoint a specialist for the rights of elderly individuals for a term of four years; specifies qualifications and duties of advocate and procedures for appeals process. (AB 510, Chapter 647, 1989 Laws, effective 10/1/89)

Recovery: If the welfare division receives a notice from a medical assistance beneficiary of their intent to settle or commence action to enforce legal liability for medical costs, the division may reduce any lien on the proceeds of a recovery to expedite the process. Prohibits the recipient's attorney to condition the amount of the attorney's fees or impose additional fees based on whether or not there is a reduction of the lien. (SB 375, Chapter 368, 1989 Laws, effective 10/1/89)

OTHER MEDICAID RELATED STRATEGIES

No Changes

INDIGENT CARE & UNINSURED PROGRAMS

Hospitals/Eligibility Determination: Allows a hospital to contract with the DHR to have a state case worker evaluate eligibility of patients applying for indigent status. Payment for those services must be made by the hospital. Provides rules for appeals and payment for patients who are determined to be eligible. The county is not required to pay the hospital for the costs of treating indigent patients until the certification is received from the administrator. (SB 40, Chapter 762, 1989 Laws, effective 10/1/89)

MCH: Allows the Department of Welfare to provide or contract for services to indigent pregnant women and children, and to adopt rules setting forth criteria for eligibility determination, rates of payment, and other necessary functions relating to the program. (AB 641, Chapter 632, 1989 Laws, effective 10/1/89)

Reimbursement for Indigent Care/Counties:

Non-county residents: The County Board of Supervisors of the county of residence of an indigent inpatient will reimburse a hospital for the costs of treating that patient as well as any nonresident indigent inpatient who falls sick in the county at a rate not less than 85% of reimbursement levels required for the same treatment of indigents provided for in the state plan. (AB 45, Chapter 783, 1989 Laws, effective 7/5/89)

Out-of-state residents: Provides state reimbursement for indigents who are injured in motor vehicle accidents by an out-of-state driver. The county is responsible for unpaid hospital charges up to $3000. (SB 373, Chapter 369, 1989 Laws, effective 10/1/89)

Residency Reauirements for Indigents: Requires that an individual reside in a county for at least 6 consecutive weeks to gain residency status. "To reside" means to be physically present at a place for at least 4 days out of each week with the intent to dwell in that place permanently or continuously. (AB 45, Chapter 783, 1989 Laws, effective 7/5/89)

NEW HAMPSHIRE

BENEFITS & COVERAGE

No Changes

ELIGIBILITY

Transfer of Assets: Reduces from 36 to 30 months the period in which individual may transfer assets at less than fair market value without considering the assets in the eligibility determination process, bringing state statutes into compliance with federal law. (HB 97, Chapter 16, 1989 Laws, effective 6/3/89)

REIMBURSEMENT

Nursing Homes/Preadmission Screening: Payment for services to individuals who are applying for medical care in SNFs and ICFs and who would become eligible within 12 months will only be made if the individual has been evaluated through the state's preadmission screening program. (HB 94, Chapter 142, 1989 Laws, effective 7/16/89)

ADMINISTRATION & MANAGEMENT

Nurse Aide Training:

HB 93, Chapter 141, 1989 Laws Defines a certified nursing assistant as a person who is authorized to provide personal care under the direction of a registered nurse of licensed practical nurse. Adds disciplinary procedures to the practice and certification program for a basic assistant to nurse education. All reports of disciplinary action must be submitted in writing to the board of nursing. Stipulates that no person may practice as a nursing assistant unless successfully completing a competency and evaluation program.

Nursing Homes/Preadmission Screening: Brings state statutes into compliance with requirements under OBRA '87 for provide preadmission assessment for all SNF and ICF nursing home applicants who may be eligible for medical assistance. (HB 94, Chapter 142, 1989 Laws, effective 7/16/89)

NEW HAMPSHIRE CONTINUED

Studies:

Dental Benefits Study Committee: Establishes 6-member legislative committee to study Medicaid coverage of dental benefits for all categorically eligible recipients. Study will include: (1) scope of services to be offered under a mandatory dental assistance plan; (2) alternative coverage plans and their fiscal impacts on the state; (3) services covered under private dental insurance plans to determine scope, participation and reimbursement rates of participants; (4) state funding necessary to establish and implement dental benefits as part of the Medicaid program; and (5) proposed legislation to be introduced in the 1990 session. Specifies membership, meetings, staff support. Requires a report to the Legislature and the Governor by 1 1/23/89. (SB 113, Chapter 393, 1989 Laws, effective 8/4/89)

Nursing Home Access Committee: Establishes a 12-member committee to study the accessibility of nursing home care; specifies membership and duties. Study will: (1) review occupancy rates and demand for nursing home services by Medicaid recipients; (2) review current practices of nursing home waiting lists and admissions, and the impact of these practices on medicaid recipients; (3) evaluate the effects on nursing homes of changing these practices; (4) review and project demand trends over the next 10 years for nursing home care for both Medicaid and non-Medicaid recipients; and (5) make recommendations for introducing legislation in the 1990 session. The first meeting will be held with 45 days of the effective date. (HB 209, Chapter 153, 1989 Laws, effective 7/16/89)

Provider Participation Task Force: Establishes an 11-member task force to examine the problem of low provider participation in the Medicaid program; specifies membership and duties. Task force must present preliminary findings and recommendations for increasing provider participation to the Legislature and the Governor by 12/1/89. The final report is due by 12/1/90. (HB 429, Chapter 291, 1989 Laws, effective 7/1/89)

OTHER MEDICAID RELATED STRATEGIES

No Changes

INDIGENT CARE & UNINSURED PROGRAMS

Access Study Committee: Establishes committee to conduct survey to measure the nature and extent of the health care access problem in New Hampshire and to develop a legislative proposal for a program that would increase the availability of basic health coverage for low-income residents. Designates membership, procedures for appointment, meeting dates and duties of the committee. A survey will provide information on the number of uninsured and low-income uninsured in the state; demographic and socioeconomic characteristics of the uninsured (including age,

employment status, family size and structure); utilization rates; and potential enrollment in a subsidized health insurance program.

A report, due to the Governor and the heads of the legislature by 12/1/89, will contain a proposal for a program to increase access to basic health care for state residents including the following: (1) a schedule of services emphasizing preventive and primary care, including all services necessary for prenatal, postnatal and well-child care; (2) a description of the plan structure (including whether it will be a prepaid, capitated plan for managed care or a fee-for-service plan), utilization review requirements and quality assurance requirements; (3) income eligibility guidelines; (4) an outline of program administration, including a description of the administering agency, and methods and procedures for marketing, eligibility determination, contracting with providers and program evaluation; and (5) recommendations for tailoring program eligibility to most efficiently reduce the gap between those eligible for Medicaid and those covered by private health insurance.

Appropriates not more than $30,000 for the biennium ending 6/30/91. Committee may seek private funds or federal matching funds as necessary. (HB 300, Chapter 332, 1989 Laws, effective 6/2/89)

Prescription Drugs for GA Recipients: Requires the Division of Human Services to reimburse each county and town for the cost of prescription drugs for general assistance recipients who are later determined to be eligible for medical assistance. Payment is retroactive to the time when the county or town rendered assistance. (HB 98, Chapter 227, 1989 Laws, effective 7/1/90)

NEW JERSEY

BENEFITS & COVERAGE

No Changes

ELIGIBILITY

No Changes

REIMBURSEMENT

Nursing Homes: Makes one-time appropriation for supplemental prospective per diem reimbursement rates for private SNFs and ICFs participating in the Medicaid program that are at or above the statewide average Medicaid occupancy level. Defines "statewide average Medicaid occupancy" as the average number of Medicaid recipients residing in each SNF and ICF divided by the total number of SNF and ICF beds in a given month. Reduces appropriation from $14.7 million to $7.5 million from each of the general fund and federal fund. Changes retroactive date from 4/88 to 10/88, and changes expiration of Act from 6/30/91 to 9/30/89. (AB 2463 and SB 2066, Chapter 18, 1989 Laws)

ADMINISTRATION & MANAGEMENT

No Changes

OTHER MEDICAID RELATED STRATEGIES

SSI COLAs: Memorializes the U.S. Congress to enact legislation requiring that the official poverty level be established annually on the effective date of a cost-of-living increase in the federal Social Security benefits, as the time lag between COLAs for SSI and revision of the official poverty level jeopardizes the financial eligibility of senior citizens and disabled individuals who are actual or prospective recipients of benefits under the new "JerseyCare" program. (AR 126, adopted 2/27/89)

NEW JERSEY CONTINUED

INDIGENT CARE & UNINSURED PROGRAMS

MCH: A new program called "Jersey MOMS" (Maternal Outreach and Managed Services) now offers a comprehensive package of prenatal health care and support services to any women seeking such care. The package will include case coordination, health education, nutrition education and assistance coordinated through the WIC program, social/psychological assessment and counseling, home visits when necessary, and referral to and follow-up with other appropriate health care providers. Under the program, women with incomes below 150% of poverty will receive the entire package at no cost; those with incomes between 150% and 250% of poverty will be asked to pay according to a sliding-fee scale, Others can purchase the services at already established rates.

Uncompensated Care: (SB 2981, Chapter 1, 1989 Laws, unless otherwise noted, this law is retroactively effective 12/31/88; The Act expires on 12/31/92)

Advisory Committee: Directs the Committee to: (1) review the methodology and assumptions used by the Department to establish the statewide uncompensated care add-on and advise the Commissioner on its conclusions about the accuracy of the calculations; (2) ensure appropriate reimbursement for hospital emergency room services according to the level of care required by the patient; (3) make recommendations to the Commissioner on the procedures that shall be used to audit uncompensated care at the hospitals; and (4) explore various initiatives to reduce the amount of uncompensated care. Adds 4 members to the Uncompensated Care Trust Fund Advisory Committee.. Adds the State Treasurer and 5 public members, (including 2 CPAs and 3 people who represent business and industry in New Jersey) to the subcommittee on hospital audit and collection practices,. Public members shall service for a term of 2 years.

Adds to the Committee's duties an analysis of the possible impact of an increased unemployment on the amount of uncompensated care provided by hospitals and to advise the commissioner on its conclusions about the projected impact of the limit on the uniform statewide uncompensated care add-on. Requires a report on cost reduction plan which is to include the names of all hospitals which have been required to submit a cost reduction plan and any actions taken by the commission against a hospital for failure to submit or implement the plan. The report must be issued by 12/1/89 (changed from 12/31/89), and it must contain recommendations by the Commissioner for an alternative means of funding uncompensated care. The Commissioner must appear before the Senate Institutions, Health and Welfare Committee and the General Assembly Health and Humans Resource Committee to discuss that report by 12/31/89.

Hospital Reimbursement:

1. Add-on Reimbursement: Caps hospital bill add-on for uncompensated care at 13%. The add-on for patients whose hospital bills are paid by an HMO or other payers which have negotiated a discounted rate of payment with the hospital will be based on the full rate of reimbursement rather than on the discounted rate of payment. This does not, however, preclude the Commission from approving individual hospital rate increases for uncompensated care in addition to the add-on. Such increases, however, will not be paid from the Uncompensated Care Trust Fund.

2. Advanced Life Support: Requires the Commissioner to establish by regulation a schedule of reimbursement rates for advanced life support services for medically indigent patients. Reimbursement for mobile intensive care unit (MICU) uncompensated care only include those uninsured patients who are classified as charity care. Reimbursement will exclude bad debt, the difference in a contractual allowance or any medical denial for a service. The cost of advanced life support services provided by the University of Medicine and Dentistry of New Jersey University Hospital to uninsured patients who are classified as charity care will be uncompensated care and will be exempt from any reimbursement limitations that apply to University Hospital. Such reimbursement will not be paid from the Uncompensated Care Trust Fund but through the reimbursement rates of University Hospital as established by the Commission.

3. Charity Care: A hospital that does not claim any deduction for bad debt for the purpose of the department's determination of that hospital's uncompensated care factor is eligible for full reimbursement for charity care for all eligible patients regardless of the patient's state of residence; does not apply to non-U.S. residents.

4. Emergency Room Services: Provides that any increases in rates of required hospital emergency services may not be solely to offset a reduction in hospital revenue that results from reduced rates for primary care provided in the emergency room. (effective l/l 1/90)

5. Payment and Recovery: Sets terms and procedures for uncompensated hospital care reimbursement, collection and recovery efforts. (effective 4/11/89)

Student Health Insurance: Requires the Student Assistance Board in the Department of Higher Education to adopt rules and regulations to require that a public or private institution of higher education consider health insurance coverage as an educational cost for purposes of determining a student's eligibility for financial aid. Does not apply to individuals participating in the REACH program. (effective 7/1/89)

Uncompensated Care Reduction/Small Business Insurance Pilot Program: Funds remaining in the Uncompensated Care Fund will be credited to a special account, known as the "Uncompensated Care Reduction Pilot Program". Funds will be used to subsidize or otherwise provide financial assistance for a health insurance pilot program for small businesses. Funds will remain in the account until a small business insurance pilot program is established by law and funds are appropriated.

NEW MEXICO

Note: Many of the 1989 changes were made through the regulatory rather than the legislative process. Regulations are cited as "HSR" (New Mexico Human Services Register) followed with volume number and date. Laws as indicated as usual with "HB" or "SB".

BENEFITS & COVERAGE

Hospice: Adds hospice care as an optional benefit under Medicaid to provide an alternative service to terminally ill recipients who wished to remain in their family home. Covered services will include room and board services outlined in the state plan for nursing home residents who elect the benefit. HCFA has also clarified that home and community-based services under the waiver program cannot be reimbursed for a hospice patient unless it can be established that they are required for a condition that is completely unrelated to the terminal condition; effective 1/1/89. (HSR, Vol. 12:06, effective 1/18/89)

ICF/MR Reserve Beds: Adds nine days per calendar year to current reserve bed days for habilitation purposes for residents of ICF/MRs as long as the increased absence is noted as part of the resident's individual program plan and services to maintain family and community ties; effective 7/1/89. (HSR, Vol. 12:42, 8/28/89)

MCH: Expands eligibility to children under the age of 4 whose family incomes are below 100% of federal poverty, and children under the age of 7 who meet the income and resource requirements under AFDC, effective 10/1/89. Age limits will increase to 5 and 8 respectively on 10/1/90. (HSR, Vol. 12:73, 10/1/89)

ELIGIBILITY

MCH: Adds presumptive eligibility for pregnant women with incomes below 100% of poverty. The needs, income and resources of the unborn child will be considered in determining the standard of need as if the child was born and living with the mother. Clients must apply for medical assistance within 15 days or presumptive eligibility will end. The presumptive eligibility period will last for 45 days while a determination is made; only one presumptive eligibility period per pregnancy is allowed; effective 4/1/89. (HSR, Vol. 12:18, 3/23/89)

Spousal Impoverishment: Sets community spouse minimum resource allowance at $30,000. (HB 21, Chapter 74, 1989 Laws, effective 9/30/89)

Veterans Health: The portion of a Veteran's Administration Improved Pension (VAIP) benefit intended for unreimbursed medical expenses will be excluded for purposes of eligibility determination. The entire amount of the VAIP benefit will, however, be counted for purposes of computation of the medical care credit; effective 7/1/89. (HSR, Vol. 12:34, 6/16/89)

REIMBURSEMENT

Hospital/Inpatient Services: Covered inpatient services for eligible recipients admitted to in-state acute care hospitals or inpatient units on or after October 1, 1989 will be reimbursed at a prospectively set rate, determined by the methodology set forth in the state plan. Excluded are (1) hospitals in within 100 miles of the New Mexico border (Mexico excluded); (2) Rehabilitation and Children's hospitals; and (3) Indian Health Service hospitals. Separate rate structures are set for these hospitals. Implementation will begin 10/1/89. (HSR, Vol. 12:56, 10/2/89)

MCH Providers: The Department will reimburse licensed midwives at a rate of 77% of the Medicaid fee for obstetric services. Midwives may also bill for delivery supplies, venipuncture for a blood sample, a hematocrit, and hemoglobin. Mileage in excess of 75 miles round trip for home visits will also be reimbursed by the Department; effective 9/1/89. (HSR, Vol. 12:68, 11/20/89)

Nursing Homes: Requires that within thirty days of eligibility determination nursing homes refund to patients all out-of-pocket expenditures except that which is required for medical care credits paid to the nursing facility for care on or after the date of Medicaid eligibility. (HB 323, Chapter 83, 1989 Laws, effective 3/17/89)

ADMINISTRATION & MANAGEMENT

Medicaid Fraud Act: Empowers the attorney general, the district attorneys, the Medicaid Providers Fraud Control Unit, and the Department of Human Services to investigate, and prosecute if they have such authority, violations of the Medicaid Fraud Act. Defines and establishes civil penalties for (1) falsification of records; (2) failure to retain records; (3) obstruction of investigation; and (3) medicaid fraud. (HB 486, Chapter 286, 1989 Laws, effective 6/16/89)

Nursing Home Reform:

Nurse Aide Training: Requests that the Health and Environment Department adopt regulations requiring nursing homes to maintain specific nursing assistant to patient ratios if the quality of care received by patients does not improve by the second session of the 39th legislature. The department must document this improvement and the work of the long-term care ombudsman program is to provide the help needed for improvement. Recommended staff-patient ratios include one nursing assistant to a

maximum of 10 patients on the day shift; one nursing assistant to a maximum of 15 patients on the evening shift; and one nursing assistant to a maximum of 20 patients on the night shift. (HM 72, adopted 1989)

Preadmission Screening: Requests the New Mexico congressional delegation to inform the secretary of the Federal HHS of the burden imposed on the state by the OBRA-87 reforms. Reports that in January and February 1989, the establishment of the pre-admission screening and resident review program has cost nearly $80,000 of state funds. This money was taken from state funds earmarked for community mental health services. Also expresses concern about the need to create alternative placement for individuals no longer eligible for nursing facilities, the lack of uniform national standards for nurse aide training and conflicting standards for nurse aide registration. (HM 15, Adopted 1989)

Prescription Drugs: Limits the estimated acquisition cost of a drug to the average wholesale price less 10.5%; effective 4/1/89. (HSR, Vol. 12:07,1/26/89)

OTHER MEDICAID RELATED STRATEGIES

TPL/Emplover-Based Health Insurance: Two companion laws, HB 368 and HB 367, make Medicaid the payer-of-last-resort. The laws require direct payment by the insurer to the provider and prohibit clauses which exclude workers eligible for Medicaid from receiving health insurance benefits under the plans. HB 368 applies to individual plans, groups plans, plans issued by fraternal benefit societies, non-profit group plans, and Medicare supplemental plans. (HB 368, Chapter 183, 1989 Laws, effective 6/16/89) HB 367 applies to plans established under ERISA. (HB 367, Chapter 184, 1989 Laws, effective 6/16/89)

INDIGENT CARE & UNINSURED PROGRAMS

No Changes

NEW YORK

BENEFITS & COVERAGE

CBS/Home Health: Adds medical social services, nutritional counseling, respiratory therapy, and home adaptation to the home and community-based services. (SI 247, Chapter 170, 1989 Laws, effective 6/89)

Personal Care/EMS: Adds emergency response services as a personal care service covered by the Medicaid program. (SI 4668-C, Chapter 438, 1989 Laws, effective 7/89)

ELIGIBILITY

CBS/Disabled Children: Provides that physically disabled children who were hospitalized or institutionalized for a specified period of time within six months prior to applying for services under the home and community-based services program are eligible to receive such services provided other eligibility criteria of such program are met. (SI 248, Chapter 171, 1989 Laws, effective 6/19/89)

MCH:

Continuous Eligibility: Continues eligibility status for pregnant women without regard to changes in family income that occur during the course of the woman's pregnancy. Eligibility is continued through the end of the month in which the 60 day post-partum period ends. The post partum period begins on the last day of pregnancy. (SI 6397, Chapter 584, 1989 Laws, effective 1/90)

Income Limits: Expands Medicaid eligibility to pregnant women and infants whose household incomes do not exceed 185% of the federal poverty level. (SI 6397, Chapter 584, 1989 Laws, effective 1/90)

Presumptive Eligibility: Incorporates presumptive eligibility into the program for the purpose of enrolling pregnant women in the Medicaid program. (SI 6397, Chapter 584, 1989 Laws, effective 1/90)

QMB's: Requires Medicaid to pay the cost sharing requirements of qualified Medicare beneficiaries with income up to 100% of the poverty level. (AI 8798A, Chapter 558, 1989 Laws, effective 1/89)

Spouse Impoverishment: Revises the income and resource limits that an individual in the community may retain when their spouse in the nursing home is applying for Medicaid, to conform with new requirements established in the Medicare Catastrophic

Coverage Act of 1988. Sets community spouse resource limit at $60,000 the maximum allowed by federal law. (AI 8798-A, Chapter 558, 1989 Laws, effective 10/89)

Transfer of Assets: Adopts the new transfer of asset requirement that prevents persons applying for Medicaid from receiving coverage for nursing home services if they transfer their assets for less than fair market value for 30 months prior to applications. (AI 8798-A, Chapter 558, 1989 Laws, effective 10/89)

Veterans Health: Exempts payments receives as a result of Agent Orange liability litigation and from the Federal Veterans' Dioxin and Radiation Exposure Compensation Act from the definitions of "income" in any means-tested state or state-assisted programs. (AI 5669-B, Chapter 743, 1989 Laws, effective 7/24/89)

REIMBURSEMENT

Claims Payments: The claims payment system will no longer pay Medicaid claims which are initially received more than two years form the date of service. (AI 1353-A, Chapter 53, 1989 Laws, effective 10/1/89)

EMS: Requires the state to pay an amount not less than the deductible and co-insurance liability when reimbursing for ambulance services provided to a person eligible for Medicare; also applies to non-Medicaid individuals. (AI 5847, Chapter 763, 1989 Laws, effective 1/90)

Hospitals:

Outpatient Surgical Services: Requires the medical assistance program to make case-based payments for ambulatory surgical services provided by hospitals and diagnostic and treatment centers from June 1, 1989 through December 31, 1990; Removes the financial penalties imposed upon hospitals which have been unable to discharge alternate level of care patients. (SI 6178-A, Chapter 753, 1989 Laws, effective 7/25/89)

Case Mix: Requires the general state increase in the statewide hospital average case-mix be applied to Medicaid reimbursement for hospitals. (AI 8849, Chapter 341, 1989 Laws, effective 7/89)

Uncompensated Care Adjustment: Assures that major public general hospitals will receive a supplementary bad debt and charity care adjustment in their medical assistance reimbursement rate. (AI 3682, Chapter 74, 1989 Laws, effective 4/89)

Hospice: Establishes the "Hospice Supplemental Financial Assistance Program" to pay additional amounts for hospice care for persons with special needs when the standard Medicaid rate, established under federal criteria, is found to be inadequate. (AI 7508-A, Chapter 725, 1989 Laws, effective 1 1/89)

NEW YORK CONTINUED

ADMINISTRATION & MANAGEMENT

Managed Care/Special Programs for Children, Elderly: Extends until April 1, 1994 the expiration dates of several of the Department's programs providing specialized services to children and the elderly and continues authorization for several capitated and managed medical care programs through such date. The programs affected include: (1) home care for physically disabled children (Katie Beckett); (2) foster family care for elderly and disabled adults; (3) prepaid health services plans and physician case management programs; and (4) guaranteed eligibility for medical assistance for home relief and aid to dependent children recipients enrolled in health maintenance organizations and prepaid health services plans. (SI 5415, Chapter 201, 1989 Laws, effective 6/27/89)

Nursing Homes/Nurse Aide Training Requires that the Commissioner of Health report neglect or inappropriate actions of nurse aides or other unlicensed individuals to the nursing home nurse aide registry. Requires that the nursing home nurse aide registry be developed and be maintained by the department of health. The registry will include names of persons who have successfully completed a state-approved nurse aide training program, the type of program completed and any disciplinary action charged. A fee of up to $165 (with annual inflation adjustments) may be charged for implementing the competency evaluation program and maintaining the nurse registry. Requires the nursing home to pay at least one competency evaluation for any nurse aide employed by them on or before June 30, 1989. (AB 6608-A, Chapter 717, 1989 Laws)

Residential Care Facilities: Requests an evaluation of the impact of medical assistance reimbursement on residential health care facilities. (AI 7465, Chapter 208, 1989 Laws, effective 6/89)

OTHER MEDICAID RELATED STRATEGIES

Hospitals/Outpatient Services/Demonstration Project: Extends until September 1, 1989 the authority of the Commissioner of Health to permit the development, implementation and operation of limited reimbursement pilot programs for general hospital outpatient services and diagnostic and treatment center services that would be prospective and associated to the resource use patterns in rendering ambulatory care services. (SI 3379, Chapter 17, 1989 Laws, effective 3/21/89)

CBS Waivers for DD Children: Directs the Department of Social Services to apply for two model waivers, under the federal home and community-based care waiver program, to serve young persons with developmental disabilities. (AI 8666-A, Chapter 729, 1989 Laws, effective 7/89)

Eligibility Demonstration Project: Authorizes eligibility demonstration programs to test the benefits of allowing persons who would be eligible for medical assistance except for having incomes that exceed the eligibility standard. Project will allow such individuals to become eligible by paying their local social service office the amount by which their income exceeds such income eligibility levels. A report to the Governor and Legislature is required by 7/93. (SI 4998, Chapter 333, 1989 Laws, effective 7/89)

SHMOs: Extends the Eldercare demonstration project in New York City, (a social health maintenance organization) for an additional year to 4/90. (SI 3379, Chapter 17, 1989 Laws, effective 3/21/89 and AI 7465, Chapter 208, 1989 Laws, effective 6/89).

LTC Demonstration Projects:

Home Health: Extends until June 30, 1990 the authority of the Department to establish demonstration programs for the delivery of long-term care home health care services. (AI 8089-A, Chapter 247, 1989 Laws, effective 7/5/89)

Insurance: Establishes a demonstration program to encourage the sale and purchase of long-term care insurance. (SI-5501-A, Chapter 454, 1989 Laws, effective 1 1/13/89)

INDIGENT CARE & UNINSURED PROGRAMS

Catastrophic Care: Revises the operation of the Catastrophic Health Care Expense program that assists families facing very large medical expenses for which they are not insured. (SI 5369-A, Chapter 676, 1989 Laws, effective 7/89).

NORTH CAROLINA

BENEFITS & COVERAGE

No Changes

ELIGIBILITY

MCH: Expands eligibility for pregnant women and infants, up to age one, to 150 % of the federal poverty level effective 1/90. Expands eligibility to children up to age 6 with family income at or below 100% of poverty effective 10/89 and children up to age 7 as of 10/1/90. (SB 44, Chapter 752, 1989 Laws)

Seousal Impoverishment: Revises the financial responsibility of a spouse for a Medicaid recipient in a nursing home to conform with provisions in the Medicare Catastrophic Coverage Act of 1988 sets community spouse minimum resource limit at $12,000. (SB 43, Chapter 500, 1989 Laws, effective 7/89)

Transfer of Assets: Revises the transfer of asset provisions in law to conform state law with federal requirements in the Medicare Catastrophic Coverage Act of 1988. (SB 43, Chapter 500, 1989 Laws, effective 7/89)

REIMBURSEMENT

MCH/Providers: Increases from $650 to $925 the global payment for obstetrical services. (SB 44, Chapter 752, 1989 Laws, effective 7/89)

ADMINISTRATION & MANAGEMENT

Nursing Homes:

Compliance/Sanctions: Establishes a nursing home penalty review committee made up of a panel of professionals to review administrative penalties assessed by the state. (HB 76, Chapter 556, 1989 Laws, effective 7/89)

Licensure/Patient Rights: Includes rule in the Patient Bill of Rights that the patient, or family, must be notified within 10 days if the facility has been notified of a violation or revocation of its license by the state. (HB 174, Chapter 75, 1989 Laws, effective 10/89)

NORTH CAROLINA CONTINUED

Nurse Aide Training: Authorizes the board of nursing to establish a nurses aide registry. Includes level I nurse aides employed in state licensed Medicare/Medicaid certified nursing facilities who have fulfilled the training and registry requirements of the board. The board may charge an annual fee of $5.00 for each registry applicant although when possible the fee should be collected from the employer. (SB 242, Chapter 323, 1989 Laws)

Methodolonv Studv: Requires the Department of Human Resources to study alternatives to current resource tests in eligibility determination that are simpler, based on recent federal legislation that permits states to apply "less restrictive methodologies" Report is due to the legislature in April 1990. (SB 231, Chapter 802, 1989 Laws, effective 10/89)

TPL: Reaffirms that a Medicaid recipient must assign to the state the right to third party benefits, and outlines the priority for payment of court costs and attorney's fees when necessary for recovery. (SB 413, Chapter 483, 1989 Laws, effective 10/89)

OTHER MEDICAID RELATED STRATEGIES

Emplover-Based Health Insurance: Removes barriers to employees for employer sponsored group health plans including: (1) firms with 50 or more employees may not require evidence of individual insurability; (2) pre-existing conditions must be covered no later than 12 months after the effective date of coverage; and (3) employees must be added after their first day of employment. (HB 467, Chapter 775, 1989 Laws, effective 1/90)

MCH/Infant Mortality: Establishes the Infant Mortality Education Awareness Project for assisting low-income women throughout the state. (SB 44, Chapter 752, 1989 Laws, effective 7/89)

INDIGENT CARE & UNINSURED PROGRAMS

No changes

NORTH DAKOTA

BENEFITS & COVERAGE

No Changes

ELIGIBILITY

Spousal Impoverishment: Conforms state statutes to federal law under MCCA. Sets minimum community spouse resource allowance at $25,000. (SB 2198, 1989 Laws, effective 10/1/89)

REIMBURSEMENT

No Changes

ADMINISTRATION & MANAGEMENT

Nursing Homes/Patient Rights: Directs the Department of Health and Consolidated Laboratories to receive and conduct appeals to accommodate residents not satisfied with the payment classification assigned through the resident classification review process established by the Department of Human Services. (HB 1194, 1989 Laws, effective 7/1/89)

Pharmaceuticals/Insurance: Prohibits third party payers from (1) preventing beneficiaries from selecting pharmacy or pharmaceutical goods; (2) imposing a copayment, fee or other condition not imposed on all beneficiaries; or (3) denying any pharmacy or pharmacist the right to participate as a preferred provider as long as the pharmacist is licensed in the state and accepts the terms of the payers' contract. Medicaid participation may be denied to any pharmacy provider that fails to comply with federal or state requirements governing the program. (SB 2283, 1989 Laws, effective 7/1/89)

OTHER MEDICAID RELATED STRATEGIES

MCCA Waivers: Allows the Department of Human Services to submit plans and seek waivers to meet requirements imposed by passage of the Medicare Catastrophic Coverage Act, and to take other action that brings state statutes into compliance with federal law. (SB 2198, 1989 Laws, effective 10/1/89)

NORTH DAKOTA CONTINUED

Studies:

Fiscal Intermediary Feasibility: Directs the Legislative Council to study the feasibility and desirability of the state contacting with a fiscal intermediary to provide Medicaid eligibility determinations and program payments. Requires the Council to report on its findings, recommendations and legislative requirements to implement such a plan. (HCR 3055, adopted 3/20/89)

Impacts of Federal Legislation: Directs the Legislative Council to study the state's systems for delivering various human services regarding mandates under the Family Support Act of 1988 to determine the most efficient, effective and responsible method of integrating or coordinating education, job training, economic development, employment, financial assistance, housing, and health care programs to low-income residents. Also directs the council to study the financial impacts on the state of implementing the MCCA. Requests the council to share findings with the Budget section of the council and to report findings and recommendations to the Legislative Assembly. (SCR 4047, adopted 3/31/89)

Nursing Home Reimbursement Methodology: Directs the Legislative Council to study the methodology for considering property costs in setting rates for nursing home care in the states. The study will review methods used in other states which eliminate consideration of actual interest and depreciation costs, and to report findings to the Legislative Assembly. (HCR 3009, adopted 3/22/89)

INDIGENT CARE & UNINSURED PROGRAMS

Health Insurance Study: Directs the Legislative Council to study the health care insurance needs of the uninsured and underinsured, including a review of legislative approaches considered by other states, and methods of meeting these needs through alternatives, such as cooperative efforts among providers, third-party payers, employers, and state and local governments. Requires the Council to report on its findings, recommendations to the legislature. (HCR 3059, adopted 3/22/89)

OHIO

BENEFITS & COVERAGE

No Changes

ELIGIBILITY

No Changes

REIMBURSEMENT

Nursing Homes:

Reserved Beds: Requires the state to reimburse nursing homes for beds reserved for Medicaid residents that are vacant because of a temporary absences. Applies only to absences that are allowed by federal regulation. (HB 112, 1989 Laws, effective 7/89)

Staffing: Requires the DHS to include the cost of staff training in the Medicaid per diem for nursing homes. (SB 113, 1989 Laws, effective 1 1/89)

ADMINISTRATION & MANAGEMENT

Nursing Homes:

Nurse Aide Training: Requires that all nurse aides receive training and a competency evaluation. Aides currently employed are to complete the program by 1/90. Thereafter, an aide cannot be employed for longer than four months without completing the program. (HB 112, 1989 Laws, effective 2/89)

ICF/MR Screening: Requires DHS to establish a separate system for assessing the needs of patients in ICF/MRs by 7/1/90. (SB 113, 1989 Laws, effective 11/3/89)

Oversight Committee: Creates a "Joint Legislative Committee on Medicaid Oversight" that is to review all facets of the state Medicaid program based on information provided by the DHS. Based on this review, the Committee is to make recommendations to the legislature and will then be terminated as of 7/91. (HB 257, 1989 Laws, effective 8/89)

Recovery: Requires the DHS to establish rules to recover benefits incorrectly paid on behalf of Medicaid recipients, including voluntary payments from recipients, liens, or other civil action in court, but not through the reduction of benefits to which the recipient is entitled. (HB 111, 1989 Laws, effective 7/89)

OTHER MEDICAID RELATED STRATEGIES

Mental Health/DD: Provides for and governs the provision of supported living for individuals who are mentally retarded or developmentally disabled, with an emphasis on independent and residential services. Requires habilitation centers to verify the availability of matching funds for Medicaid reimbursement of habilitation services. Requires the Director of MR/DD Services to adopt rules specifying standards and procedures for the certification of habilitation centers and to certify centers. Requires county MR/DD boards to certify respite care homes. (HB 257, 1989 Laws, effective 8/89)

INDIGENT CARE & UNINSURED PROGRAMS

Employer-Based Health Insurance/Demonstration Project: Requires the Department of Health to distribute funds as grants to be used to establish demonstration projects that test alternatives for providing affordable sickness and accident benefits to employed persons and their dependents through partnerships between employers, employees, HMO, insurers, government agencies and charitable organization. The funds can only be used for persons that did not previously have insurance through their employer, and whose family incomes are at or below 200% of the federal poverty line. Grants are to be awarded by 9/89 with funding continuing through 9/91. (HB 24, 1989 Laws, effective 6/89)

Insurance: Authorizes sickness and accident insurance companies in Ohio to offer group health insurance contracts to tax-exempt charitable foundations that issue certificates of coverage to persons with incomes that are no greater than 100% of the federal poverty line. (HB 257, 1989 New Laws, effective 8/89)

OKLAHOMA

BENEFITS & COVERAGE

AIDS/Prescription Drugs: Expands the medical necessity criteria for coverage of Retrovir under Medicaid to require the following: (1) Diagnosis of AIDS -- laboratory evidence of HIV infection and a prescription by any licensed physician; and (2) Diagnosis of ARC verified by specialist in the treatment of HIV infection or: a) laboratory evidence of HIV infection; b) supporting clinical data which indicate persistent and ongoing evidence of physical or immunologic decline on the part of the patient which is attributable to HIV infection and accompanying syndromes; and c) a prescription by a specialist in the treatment of HIV infection. Applies to all Medicaid eligible recipients. (Regulation, effective 5/1/89)

EPSDT: Revises the EPSDT periodicity schedule to conform to the recommendations by the Oklahoma Chapter of the American Academy of Pediatrics. The frequency of health screenings as well as extending health screenings through age 20 were included in the revisions. (Regulation)

ELIGIBILITY

No Changes

REIMBURSEMENT

EPSDT: Revises EPSDT to include payment for glasses for children with congenital aphakia or following cataract removal. (Regulation)

ICF/MR: Increases ICF/MR per diem reimbursement rate to $52. Included in the new rate is the requirement that a minimum of $25 per day be spent for direct care staff salaries. The payment of ancillary services in the form of dental care and adaptive equipment will be covered outside the rate on a preauthorization basis. (Regulation, effective 7/1/89)

ADMINISTRATION & MANAGEMENT

Fraud: Establishes the Oklahoma Medicaid Program Integrity Act and allows the Medicaid Fraud Control Unit with the Office of the Attorney General to investigate and prosecute fraud and abuse on the part of recipients and services providers. (SB 1447, Chapter 220, 1989 Laws, effective 7/1/89)

Mental Health/CBS for Children: (HB 1378, Chapter 345, 1989 Laws, effective 7/1/89)

Evaluation: Mandates that the DHS arrange for an independent evaluation by a qualified mental health professional of a child who has been determined by the court to need treatment and has been placed in the custody of the DHS. This does not apply to children who have been placed in state custody as deprived or delinquent children, or children needing supervision, or children placed through a protective order or similar order that requires the DHS to conduct the evaluation.

Inpatient Services: Requires DHS to conduct review after the first 60 days that Medicaid-eligible or custody children are placed in inpatient facilities to determine if continued inpatient care is required and appropriate.

Optional Services: Requires the Department of Human Services (DHS) to include in the Medicaid State Plan a service plan for reimbursing all available home and community-based optional services for children and youth.

Waivers: Directs DHS to apply for all available waivers which will assist in the development of community-based mental health services and drug and alcohol treatment for individuals 18 and under.

Mental Health/Staffing/Children's CBS: Authorizes and funds an additional 40 child welfare workers within DHS and appropriates $1,742,500 for the development of community-based services for individuals 18 and under. (SB 82, Chapter 373, 1989 Laws, effective 7/1/89)

OTHER MEDICAID RELATED STRATEGIES

LTC:

LTC Ombudsman: Creates the Office of the State Long-Term Care Ombudsman within the DHS to advocate for residents of long-term care facilities. The Commission for Human Services is responsible for establishing rules or regulations concerning the powers, duties and qualifications of the State Long-Term Care Ombudsman, and the training requirements for the ombudsman staff and volunteers. The State Council on Aging will act as an advisory board to the ombudsman. (SB 299, Chapter 326, 1989 Laws, effective 5/26/89)

Life Care Contracts: Places life care community policies, which are contracts for a place of residence and personal care services, within the scope of the Long-Term Care Insurance Act. Because they are not insurance policies, they are regulated only by the LTC Insurance Act and are not subject to other provisions of the State Insurance Code. (HB 1167, Chapter 107, 1989 Laws, effective 11/1/89)

OKLAHOMA CONTINUED

Nursing Homes/Abuse: Requires DHS to refer reports of abuse and neglect of the elderly and incapacitated persons in nursing facilities for investigation. Places a moratorium on new or expanded long-term care services until 6/30/89 (the moratorium was not extended). Requires DHS to conduct a study of alternative methods of service delivery for nursing home residents. A report is due to the Governor by 9/30/89 (HB 1249, Chapter 227, 1989 Laws, effective 8/25/89)

State Commission: Establishes a 12-member Health Organization Study Commission to review and make recommendations regarding: (1) the administration of state health regulatory functions; (2) the delivery of services; and (3) the structural organization of health-related responsibilities within state government. The commission must make an interim progress report to the Governor and Legislature by 10/31/89 and a final report by 1/31/90, at which time the commission will be terminated. (HB 1068, 1989 Laws, effective 7/1/89)

Adult Dav Care: Allows the Department of Health, with the advice of the Long-Term Care Facility Advisory Board, to define minimum licensure requirements and regulations for adult day care centers for the frail elderly. Increases representation on the Long-Term Care Facility Advisory Board from 18 to 22 people, including 3 members who are owner-operators of adult day care facilities and 1 additional member who is over 65 and representative of the general public (this brings the total to 5 the number of representatives in this category). (SB 88, Chapter 192, 1989 Laws, effective 1 1/1/89)

INDIGENT CARE & UNINSURED PROGRAMS

MCH: Appropriates $950,000 for the provision of perinatal services to low-income women statewide to be used as follows: (HB 1068, 1989 Laws, effective 7/1/89)

High Risk Pregnant Women: $715,000 for direct services in unserved or underserved counties and to encourage early entry of high risk clients into the health care system.

Providers: $180,000 for contracting services with the Perinatal Continuing Education Program of the Department of Obstetrics and Gynecology, University of Oklahoma College of Medicine.

Teen Pregnancy Demonstration Project: $55,000 to establish a demonstration program for preventive and comprehensive prenatal care services to be located in a select county with a high teen pregnancy rate. Services shall include ambulatory care, community organizing and case management, social work and nutrition, public education, and follow-up services.

OREGON

BENEFITS & COVERAGE

Child Support: In cases where child support is ordered by the court, the individual to whom the rights are assigned may elect to receive medical support through the Medicaid program. Expands "Duty of Support" to include a duty to provide medical and dental insurance coverage for dependents. (HB 2454, Chapter 812, 1989 Laws, effective 10/3/89)

LTC Case Management for Disabled/Insurance: Authorizes the Senior and Disabled Services Division to contract with private entities to provide or contract for case management services for long-term care insurance for elderly and disabled populations. (SB 875, Chapter 787, 1989 laws, effective 10/3/89)

ELIGIBILITY

No Changes

REIMBURSEMENT

No Changes

ADMINISTRATION & MANAGEMENT

Fraud: When prosecution of a case involves Medicaid funds and two or more counties are involved, the trial may be held either in the county in which the claim was submitted or in the county in which the claim was paid. (HB 2468, Chapter 384, 1989 Laws, effective 10/3/89)

Home Health/Hospice Licensure: Current law is amended to require that certified or accredited hospices need a license to operate if they meet the definition of a home health agency and receive direct compensation for home health care services form the patient, insurers, Medicare, or Medicaid. If a hospice does not meet the definition or receive direct compensation for home health care services, no license is required. (SB 794, Chapter 697, 1989 laws, effective 10/3/89)

LTC/Commission/Disabled Services: Eligibility for Medicaid, financial assistance and food stamps for adult disabled, blind, and elderly individuals who were not part of the long-term care system were split out from the Adult and Family Services Division

(AFSD) and incorporated into long-term care services under the Senior Services Division (the division is now called the Senior and Disabled Services Division--referred to from now on as the SDSD). Creates the Oregon Disabilities Commission to develop a long range state plan for programs and services to the disabled population. (SB 875, Chapter 787, 1989 laws, effective 10/3/89)

Nursing Homes:

Nurse Aide Training: Makes it unlawful to sell or fraudulently obtain or furnish a certificate to a person not certified as a nursing assistant. Amends sections pertaining to the establishment of training programs for nursing assistants by the board of nursing. This includes sanctions for use of any controlled substance or intoxicating liquor in a dangerous manner. (HB 2059, Chapter 800, 1989 Laws)

Staffing: Authorizes the Senior Services Division to conduct a study of the feasibility of establishing a standardized staff-to-patient ratio that meets individual patient needs in nursing homes. Appropriates $25,000. (HB 2956, Chapter 665, 1989 Laws)

NURSING HOME REFORM/PREADMISSION SCREENING:
(SB 536, Chapter 912, 1989 laws, effective 8/2/89)

Advisory Committee: The Assistant Director of the SDSD must appoint an advisory committee to advise the Division in certifying and decertifying programs for admission assessment. The committee will consist of representatives form the Oregon Association of Hospitals, the Oregon Health Care Association, the Oregon Association of Homes for the Aging and representatives of senior citizens.

Appropriations: The law authorizes changes in expenditures as follows: $143,808 is deleted from state long-term care general funds and appropriated for administrative expenses; under general state administration funds, $145, 704 other funds is appropriated for administration of the program; and under the state's federal funds appropriation, $239,528 is deleted from the long-term care program and $804,798 is added for administrative expenses.

Assessment: Requires the SDSD to establish procedures for assessing the long-term care needs of all individuals who are either applying to ICFs or who have been in SNFs for more than 30 days and who do not appear to be eligible for Medicaid. The assessment must include information regarding appropriate services and placement alternatives including nursing facilities and community-based settings; includes all services necessary to comply with federal regulations concerning preadmission screening established by HCFA under OBRA 1987 including the following: (1) specifies time periods for assessment procedures; (2) gives the Division certain authority to establish and provide information and educational activities; (3) accepts referrals and assess long-term care needs of those individuals; (4) identifies available noninstitutional services to meet needs of referred individuals; and (5) determines minimum qualifications for members of the admission assessment team.

Assessment for Non-Medicaid Clients: Individuals applying to facilities that are not Medicaid certified must be advised and sign a disclosure form signaling their understanding of the availability of the admission assessment at the applicant's own expense. The SDSD may establish a fee and provide assessment services to such individuals upon request. The division will also set a maximum fee that a certified program may charge in this situation.

Certification: After consulting with this committee, the Division will adopt criteria and procedures for certifying assessment programs and contracting with the certified programs for conducting the assessment. The division must set a minimum fee that a certified program may charge for assessment services; however, the individuals on whom the assessment is made may not be charged a fee for the assessment. Once applicants receiving assessment have met the minimum federal criteria, they are entitled to additional assessment services and information on the appropriate placement alternatives. The law gives an applicant the right to choose among any available placement options.

Evaluation: The SDSD must report to the legislative assembly on 1/1/91 regarding: (1) the number of people who have been assessed; (2) the level of care needed at the time of admission assessment; (3) the amount spent on alternatives to nursing home care; (4) the length of time until a Medicaid application is necessary--ie: the client's spend down time; (5) the amount of private money which would have been spent without alternative care; (6) the amount of Medicaid funds that would have been spent without alternative care; and (7) the average cost per admission assessment. Implementation is subject to federal fund participation of admission assessment activities.

OTHER MEDICAID RELATED STRATEGIES

CBS for DD: Memorializes the U.S. Congress to assure introduction and passage of a bill to amend Title XIX to provide funds for individuals with disabilities who receive services in community-based settings. (SJM 4, adopted 3/20/89)

Cost-Containment Committee: Revises membership of the Health Care Cost Containment System Advisory Committee to decrease the number of members on the committee and somewhat change representation. The new committee will now consist of 1 representative from each of the following organizations: the Oregon Medical Professional Review Organization, the Health Division, and the Adult Family Services Division. In addition, the committee will also have 1 representative from an HMO under contract with the AFSD, 2 representative from different physician care organizations under contract with the AFSD, 1 private sector professional with experience in capitated health care, 1 health economist, 1 registered nurse practicing in a managed care setting, 1 mental health practitioner, and 2 consumer representatives. (Previously the task force included 1 person from each of the following organizations: the Oregon Medical Association, the Oregon Hospital

Association, Blue Cross Blue Shield, each organization under contract with the AFSD, each foundation of medical care operating in Oregon, a health economist appointed by the Director of Human Resources; 2 consumer representatives, and 2 representatives from the AFSD.) The advisory committee will serve as a consulting body to the AFSD regarding future changes in the Oregon Health Care Cost Containment system. (HB 2140, Chapter 513, 1989 Laws, effective 10/3/89)

HEALTH SERVICES PRIORITY LIST (SB 27, Chapter 836, 1989 Laws, effective 7/26/89)

Introduction: This law sets up a prioritized list of medical services that will be made available to recipients under the Medicaid program. All services on the list that are provided (as determined by the Health Services Commission--see below) must be made available in full scope (also determined by the Commission) to all recipients. The number of services offered will be determined by the availability of funding. The program will be administered by the Adult and Family Services Division (AFSD). Implementation of the program requires the AFSD to obtain federal waivers; it also requires the Emergency Board to vote to authorize release of the appropriation for the second year of the 1989-91 biennium. The understanding is that some minimum level of benefits will be required under the federal waiver as a condition of the program; however, it is not clear exactly what configuration of services it will include. The state has requested that Senator Bob Packwood intervene on its behalf to obtain U.S. Congressional waivers that would: (1) expand eligibility to all people below the federal poverty level regardless of family status (currently single and childless couples are not eligible for Medicaid); and (2) possibly exclude certain categories of hospital and physician services that are required under Title XIX. At the time of this writing, no federal waivers have been granted for this program.

Administration:

Appropriations: For the 1989-91 biennium, the law appropriates $173,780 in state funds to contract with the Executive Department for administrative expenses for the Commission, and $523,567 in state funds for administrative expenses incurred by the AFSD.

Commission: Establishes the Health Services Commission consisting of 11 members appointed by the Governor. Five members must be physicians with clinical expertise in obstetrics, perinatal care, pediatrics, adult medicine, geriatrics or public health. One of the physicians must be a Doctor of Osteopathy. The remaining 6 members shall include a public health nurse, a social services worker, and four consumers of health care. Term of service is four years except for the first commission where the term of service is set between 1 and 4 years to allow rotation. Only travel expenses may be compensated.

The Commission, in consultation with the Joint Legislative Committee on Health Care, will conduct public hearings and obtain testimony from providers, payers, consumers, and advocates of health care; and they will solicit public involvement to build consensus on the values to be used to guide health resource allocation decisions. The Commission will then develop a list of health services ranked by order of importance representing the comparative benefits of each service to the entire population to be served. The recommended list must be accompanied by a report by an independent actuary who will determine the rates necessary to cover the costs of the services.

Reporting Reauirements: The report for the 1989-91 biennium is due to the Governor, the Joint Legislative Committee on Health Care, and the Emergency Board by March 1, 1990; thereafter the report is due to the Joint Legislative Committee by July 1 of the year preceding the legislative session. For the 1989-91 biennium only, the Emergency Board will fund the report to the extent that funds are available. After 1991, the Joint Legislative Committee on Health Care will determine whether or not to recommend funding of the Health Services Commission's report to the Legislative Assembly and will advise the Governor of its recommendations. Neither the Emergency Board nor the Joint Legislative Committee are authorized to alter the list of services developed by the Commission. The Legislature will then be responsible for funding the list of services contained in the report.

Benefits & Coverage:

Coverage: Services to be included in the priority list include the following broad categories: (1) provider services and supplies; (2) outpatient services; (3) inpatient hospital services; and (4) health promotion and disease prevention services. The law requires providers to advise patients if they need "medically necessary" services that are not covered under the priority list. The law also exempts providers from criminal prosecution, civil liability or professional disciplinary action if the providers fail to provide services not covered under the priority list. As yet, however, there is no mechanism for determining if patients will be able to receive such services, or how the services will be financed. Ostensibly, provision of an unlisted service would be at the discretion (and expense) of the provider and/or would require out-of-pocket expenditures by the recipient.

Exemotions: Exempt from priority list are (1) nursing facilities and home- and community-based waivered services funded through the SDSD; (2) medical assistance for the aged, blind and disabled; (3) institutional, home- and community-based waivered services, the Community Mental Health Program which provide services for the mentally retarded, developmentally disabled, chronically mentally ill, emotionally disturbed, and for treatment of alcohol- and drug-dependent clients; (4) services to children who are made wards of the state through the juvenile courts; and (5) services to children and families for health care or mental health care through the Children's Services Division.

Funding & Service Reductions: If the available public funds are not sufficient to cover the entire list of services recommended by the Commission's report, neither eligibility standards for beneficiaries nor reimbursement rates for providers will be reduced. Instead, the services will be eliminated in reverse order of priority as listed in the report until the available funding covers the remaining services. The AFSD must obtain approval from the Legislative Assembly or, if the Assembly is not in session, the Emergency Board before instituting reductions. Providers must be notified at least 2 weeks prior to any legislative consideration of such reduction. Any reductions that are approved will go into effect no sooner than 60 days following final legislative action approving the reductions.

Eligibility: Expands eligibility to include other low-income persons defined as those with family incomes below the federal poverty level who are not eligible for Medicare (see Indigent Care below).

Reimbursement: Services will be provided under prepaid managed care contracts to the extent possible. The contract must provide services to the extent and scope as listed in the Commission's report and funded by the legislature for each service included in the contract. The intent of the legislation is that the services will be fully provided under managed care contracts. However, if there are insufficient qualified providers in certain areas of the state, the state may use partial service managed care contracts, a fee-for-service case management system, or continue with a non-managed fee-for-service system for the same services as those listed in the Commission's report and funded by the legislature. Contracts will begin on or after July 1, 1990 and will be offered for one year. This means that the providers will have to be requalified and the contracts will be renegotiated each year as the priority list changes based on the availability of funding.

DISABLED SERVICES: (SB 875, Chapter 787, 1989 laws, effective 10/3/89)

Administration: This law authorizes the SDSD to assist the local division units and Type B agencies to stimulate more effective use of existing resources and to develop programs, opportunities and services which are not otherwise provided to the disabled population. The goal is to develop a comprehensive and integrated system for delivery of services to the disabled population. It also requires the SDSD to determine the annual budget levels for planning and administering programs related to social, health, independent living and protective services for the disabled and Type B2 agencies

Local Advisory Councils: Requires the division to establish advisory councils in each area to advise its disability service units on basic policy guidelines for clients receiving its services, and to review and evaluate the effectiveness of the services provided by the division. The committee must have a majority of its members be disabled and include consumers and other interested parties. The advisory council must meet at least quarterly. Councils for Type B2 agencies must establish a disabilities issues committee composed of at least 5 members to advise the agency on disability issues.

Local Programs: Three types of local agencies currently provide services to the elderly population--local division units of the SDSD and two types of "Area Agencies on Aging", Type A and Type B. Type A agencies are local community or consumer groups that provide services to the elderly using state funds; Type B agencies are regional or local agencies under government jurisdiction (general at the county level). Prior to the transfer of responsibility for disability services to the Senior Services Division, each Area Agency on Aging was required to have a "Disability Issues" Committee as part of its advisory board. This law repeals that requirement and gives Area Agencies on Aging the option to accept responsibility for only those programs and clients who are elderly. Agencies choosing this option will be called Type **B1** agencies. Under this scenario, local responsibility for long-term care and medical services under Medicaid for the disabled population under 65 years of age will be returned to the SDSD and administered through the local division units. In order that Type **B1** agencies are not confused with Type A agencies (local community groups), advertising for disability services will be conducted by the division. Alternatively, the Area Agencies on Aging may elect to accept responsibility for all programs and clients who are transferred, that is, services for both elderly and the disabled. These agencies will be called Type B2 agencies.

Transfer of Responsibility: Transfers responsibility from the Adult and Family Services Division (AFSD) to the Senior and Disabled Services Division (SDSD) for all individuals over 18 years of age (and most likely all SSI children) who currently receive the following services from AFSD: (1) general assistance; (2) SSI except those who are members of households receiving AFDC; (3) aid to the disabled and the blind, including medically needy services; (4) old-age assistance, including medically needy services; (5) aged, blind and disabled persons receiving Medicaid who are not members of households receiving AFDC; and (6) nonassistance food stamps to individuals who are over 60 years or who live in households where the head is 60 years of age or older. Transfer of these cases must be completed by 10/1/90. In addition, the following policy-setting functions, resources, and support activities related to the transferred programs and clients will also be transferred from the AFSD to the SDSD: (1) trust and agency (the ability of the state to act on behalf of a client); (2) estate administration; (3) training; (4) accounting budgeting and data processing; (5) program monitoring and recoveries; and (6) miscellaneous medical including durable medical equipment. Establishes a planning and transition committee to advise the SDSD on the general direction and philosophy of the transfer. The committee will consist primarily of representatives of the disabled and aged community.

INDIGENT CARE & UNINSURED PROGRAMS

Universal Access: Requests the 101st Congress to enact a National Health Plan that would include at least the following components: (1) universal access; (2) comprehensive basic benefits including but not limited to inpatient, outpatient, surgical and **medical benefits, diagnostic and laboratory services, maternity benefits,** substance abuse benefits, mental health benefits, long-term care, and preventive

services; (3) cost-containment measures to eliminate inefficiency, unnecessary procedures, unwarranted expansions, and excessive or unneeded capital investments; and (4) high quality care. (SJM 20, adopted 5/11/89)

PRIVATE SECTOR INITIATIVES: (SB 935, Chapter 381, 1989 Laws, effective 10/3/89)

This law expands health insurance coverage for low wage workers in small firms or firms with a large number of low-wage workers by subsidizing employers* premiums both directly and through a tax credit. It also creates a state insurance pool to increase access to the working uninsured. The pool will be funded by employers who do not participate in the state subsidy plan and who do not offer coverage to their workers.

State Health Insurance: Creates State Insurance Pool for the purpose of collecting and distributing funds to increase access to the working uninsured. Requires all employers who have not provided employee and dependent health care benefits to their workers and who are not participating in the state subsidy plan to pay a fee equal to the contribution set by the board. The payments will be based on a percentage of taxable payroll equivalent to 75% of the cost of a basic health benefits package (as determined under SB 27) and 50% for dependent coverage. The plan will most likely require the worker to pay the rest up to a certain limit. The Insurance Pool may exempt employers due to hardship and fix the terms and conditions of the exemption. An appeals process is also included for exemptions that are denied by the Board. The Pool is also responsible for providing data to the Oregon Health Council for monitoring and evaluating the adequacy and effectiveness of the health benefits available under this law.

The Pool will consist of seven members (changed from five), six of whom are to be appointed by the Governor. Of those six, two must be employers and one must be an employee who represents organized labor; two must have knowledge about insurance but may not be officers, employees, nor consultants to a carrier or contractor. The seventh member will be a consumer representative appointed by the Division of the Department of Insurance and Finance. Term of office is three years at the pleasure of the appointing authority. No position may be vacant longer than 60 days.

State Subsidies for Small Businesses:

Administration/Implementation Requirements: The law specifies that the program will only go into effect if SB 27 passed, which it has. It is not, however, contingent on Oregon obtaining the necessary federal waivers required under SB 27. The program is in effect at the time of this writing.

Benefits & Coverage: Coverage provided by employers will include the same list of services as developed by the Health Services Commission under SB 27 (includes medically needy with family incomes below the federal poverty level, categorically needy, and other Medicaid eligibles) and covers all participating eligible recipients.

Eligibility: The employer subsidy plan is limited to those employers with no more than 25 employees who do not have health insurance through a family member or other sources. (This means that an employer with more than 25 employees is eligible for the subsidy as long as fewer than 25 of those employees do not have insurance coverage from any source.) Another condition of eligibility is that the employer may not have contributed to any group health insurance in the last 2 years. After July 1, 1991 the Legislative Assembly may establish a health insurance program for employers who employ more than 25 workers or employers with 25 or fewer workers who have provided health insurance. Contributions by employers towards coverage for themselves or their dependents does not disqualify them under the two-year requirement mentioned above. The law also eliminates language that will be in conflict with SB 27.

Reimbursement/Premiums: Employers are required to pay a maximum of $40 per month for each eligible employee. The employer may require a minimum contribution by the employee of up to 25% of the premium or $15, whichever is less for only PART I (services funded under SB 27). The premiums established under this law only apply to those employers who qualify for tax credits under current Oregon tax laws.

Employer Tax Credit:

Evaluation: Before 1/1/92, the Insurance Pool Governing Board must publicly report the number of employees who are receiving health benefits through employment as of 10/1/91 and who did not receive benefits prior to 4/1/89. If the number exceeds 50,000, the $25 tax credit will be extended another year and the tax credit reduction schedule will be postponed until 1992, (ie: so that the tax credit will be $18.75 in 1992 and $12.50 in 1993). This procedure will take place again before 1/1/93 for workers covered by 10/1/92. If the number of covered workers exceeds 100,000, then the tax credit for 1993 will remain at the 1992 level ($18.75 per covered employee per month) instead of being lowered to $12.50 per employe per month and further reductions will not take place until the following year. Before 1/1/94 the Board must again report on the number of covered workers; if that number exceeds 150,000 then the Insurance Fund Pool will be disbanded.

Incentives **for Increasing Worker Coverage:** The old law used a percentage formula for determining the tax credit but contained a loophole that gave employers a tax credit equal to the amount specified for the first year (ie: $25 per employee per month) regardless of what year the employer began participating in the state subsidy plan. The law was rewritten specifying the dollar amount for each year to create an incentive for employers to enter the program sooner rather than later.

The Program: All employers eligible for the state subsidy will be allowed a tax credit. The program may be the lesser of: (1) 50% of the total amount paid during the taxable year; or (2) the following tax credit schedule--$25 per eligible per month in 1989 and 1990, $18.75 in 1991, $12.50 in 1992 and $6.25 in 1993. Tax credits which are allowable but not used in a given tax year period may not be carried forward to offset an employer's tax liability for the next year. The health coverage provided under this law is a pre-tax benefit to the employee and will not be included as taxable income. The tax credit ends 12/31/93.

All new employers will be allowed 18 months lead time before payments are required. If the employer provides employee and dependent coverage within the first 18 months of the commencement of the business, the employer is eligible for a tax credit of $25 per month per eligible covered or 50% of the total amount paid premiums during the taxable year, whichever is less. This tax credit applies for one year, then whatever tax credit is applied under the evaluation process (see below) will be in effect.

PENNSYLVANIA

BENEFITS & COVERAGE

No changes

ELIGIBILITY

CBS/DD: Memorializes the U.S. Congress to demonstrate its support for allowing states to provide Medicaid-reimbursed community-based programs to people with developmental disabilities who live with their families, in their own homes, or in small family-scale environments by passing U.S. Senate Bill 384, the "Medicaid Home and Community Quality Services Act of 1989". (SR 44, adopted 6/20/89)

REIMBURSEMENT

CBS/DD: Memorializes the U.S. Congress to include autistic individuals among those eligible to receive community-based residential care, thus eliminating the inconsistency in federal regulations that reimburses community-based residential services for individuals with other mental disorders but not autism. (SR 39, adopted 6/20/89)

ADMINISTRATION & MANAGEMENT

No changes

OTHER MEDICAID RELATED STRATEGIES

No changes

INDIGENT CARE & UNINSURED PROGRAMS

No changes

RHODE ISLAND

BENEFITS & COVERAGE

Adoption/Special Needs Children: Requires the state to provide medical assistance to adopted special needs children for whom the state has provided adoption assistance, regardless of whether or not the parents are eligible. Requires continued assistance even if the child's state of residence is changed. (HB 5546, Chapter 89-259, 1989 Laws, effective 7/7/89)

ELIGIBILITY

Medically Needy: Directs the Department of Human Services (DHS) to establish rules and regulations for income and resource standards for its medically needy program. (HB 6910, Chapter 89-53, 1989 Laws, effective 7/1/89)

Spousal Impoverishment: Supports DHS efforts to finance the proposed increase in the monthly income allowance of community spouses. (HB 6416, Resolution 89-171, 1989 Laws, adopted 6/22/89)

REIMBURSEMENT

Fraud: Allows the DHS to suspend payment to a provider under the following conditions: (1) the Medicaid Fund Control Unit of the Attorney General's Office has been denied reasonable access to information about a current or previous patient or resident of a LTC facility; (2) the Medicaid Fund Control Unit or the Rhode Island Medicaid program has been denied access to data and information by the provider for evaluating compliance with standards of care; or (3) the Rhode Island Medicaid Program has reliable evidence that the provider has engaged in fraud or willful misrepresentation under the Medicaid program. (HB 6998, Chapter 89-137, 1989 Laws, effective 7/1/89)

LTC: Supports DHS efforts to finance proposed increased in Medicaid reimbursement for LTC providers. (HB 6416, Resolution 89-171, 1989 Laws, adopted 6/22/89)

QMBs: Establishes that medical assistance payments for Medicare premiums and other health insurance premiums by the DHS are deemed to be a direct vendor payment. (HB 6910, Chapter 89-53, 1989 Laws, effective 7/1/89)

Visiting Nurses/Home Health: Defines Visiting Nurses Associations and specifies reimbursement formula for visiting nurses: 10% is divided equally among the specified agencies; 90% is apportioned according to each agency's share of home visits. (HB 6976, Chapter 89-305, 1989 Laws, effective 7/7/89)

ADMINISTRATION & MANAGEMENT

Fraud:

Appeals: Reduces the time period from 40 to 20 days that an individual may appeal a Medicaid fraud demand to the state superior court. (HB 6986, Chapter 89-429, 1989 Laws, effective 7/1/89)

Program Definitions: Defines and clarifies fraudulent acts under the Medicaid program. Sets statute of limitation for any violation at 10 years. (HB 6984, Chapter 89-501. 1989 Laws, effective 7/1/89)

Nursing Homes:

Nurse **Aide/Licensure:** Establishes a $20.00 registration fee for nursing assistants to be certified by the department of health. Also, requires written notification of patient transfers. (HB 5995, Chapter 89-270, 1989 Laws)

Patient Rights: Amends the rights of nursing home patients to require that information be displayed in a conspicuous place in a nursing home, including a summary of major provisions, health department addresses and phone numbers and notice of availability of public information regarding results of state and federal surveys of nursing homes. (HB 5757, Chapter 89-265, 1989 Laws)

OTHER MEDICAID RELATED STRATEGIES

Alzheimer's Disease: Stipulates that any individual regardless of age who: a) is afflicted with Alzheimer's disease or severe dementia; b) pays for services with his or her own funds; and c) is not eligible for Medicaid, is eligible for case management services under the "Nursing Home Without Walls" program. Extends provisions and reporting requirements to 6/30/90. (HB 7225, Chapter 89-442, 1989 Laws, effective 7/1/89)

RHODE ISLAND CONTINUED

INDIGENT CARE & UNINSURED PROGRAMS

Hospitals: (HB 6463, Chapter 89-480, 1989 Laws, effective 7/1/89)

Financing and Delivery Commission: Establishes a 19-member Blue Ribbon Commission to: (1) develop policy recommendations to ensure continued delivery of comprehensive and cost-effective hospital services; (2) study hospital financing and uncompensated care; and (3) devise a system to meet the need of the state's residents. Specifies membership. Report is due to the legislature by 2/16/90. Commission expires 4/16/90.

Uncompensated Care Grants: Establishes a uncompensated care grant program for financially distressed hospitals. Specifies 15 hospitals for participation; defines terms, conditions and reporting requirements of grant program. Specifies formula for funding. Appropriates up to $1.5 million for grants. Authorizes payments in two installments--10/1/89 and 6/29/90. Expires 6/30/90.

MCH: Establishes program covering maternity services for indigent pregnant women whose income is below 185% of the federal poverty level. Program includes referral for non-covered services, care coordination, nutrition and social service counseling, high risk obstetrical care, childbirth and parenting preparation programs, smoking cessation programs, outpatient counseling for substance abuse and interpreter services. (HB 5417, Chapter 89-252, 1989 Public Laws, effective 7/7/89)

State Health Insurance Study: Extends reporting date for study of universal health insurance (established by HR 244, 1988) until 2/6/91 and expiration date of the commission to 4/6/91. Increases commission membership to 30 members; specifies membership. Commission will study the feasibility of establishing universal health insurance for the state, including cost-containment issues. (HB 5405, Resolution 214, 1989 Laws, adopted 7/7/89)

SOUTH CAROLINA

BENEFITS & COVERAGE

MCH/Elderly and Disabled/MN: New "Expansion Fund" will provide coverage for: (1) pregnant women and infant with family incomes up to 185% of the federal poverty level; (2) Medicaid coverage to children up to age 6 with family incomes up to 100% of poverty; (3) Medicaid coverage to aged and disabled persons with family incomes up to 100% of poverty; and (4) Medicaid coverage through the medically needy program. (HB 3600, 1989 Laws, effective 1989)

Personal Care Aide Services: Services were implemented, effective 10/1/89.

Prescription Drugs: Medicaid will now pay for a maximum of four prescription drugs per month per recipient, up from three. (effective 7/1/89)

ELIGIBILITY

QMBs: Authorizes full Medicaid coverage to Qualified Medicare Beneficiaries with family incomes at or below 100% of the federal poverty level. (HB 3600, 1989 Laws, effective 6/89)

REIMBURSEMENT

Hospitals/Inpatient Services: Requires prospective payment to hospitals to be adjusted every two years to reflect the most recent cost data. Expansion Fund will provide reimbursement for hospital patients in need of subacute care, including patients in swing beds and additional reimbursement for disproportionate share hospitals. (HB 3600, 1989 Laws, effective 10/89)

LTC: Directs the State Health and Human Services (SHHS) Finance Commission to obtain an inflation factor in calculating a reimbursement rate for long-term care facilities. The Commission may use an inflation factor from zero up to the inflation factor developed by the Budget and Control Board. (HB 3600; 1989 Laws, effective 6/89)

SOUTH CAROLINA CONTINUED

ADMINISTRATION & MANAGEMENT

Eligibility Study: Directs the SHHS Commission to study the methods used in other states to determine eligibility for persons applying for medical assistance only, and not cash assistance, and develop recommendations concerning the best method to be used in South Carolina. Report must be delivered to the legislature 1/90. (HB 3600, 1989 Laws, 6/89)

Expansion Fund: Creates a Medicaid expansion fund from state general revenues, county assessment, hospital tax and federal match. Funds will be available for state and hospital reimbursement for the cost of collecting and reporting hospital data; and administration of the medically needy program. Any funds left over will go towards reimbursing hospitals for services provided under the state Medically Indigent Assistance program. (HB 3600, 1989 Laws, effective 10/89)

Nursing Homes/Capital Costs: Authorizes a study on the capital costs related to nursing care facilities. Directs that the cost of capital shall not exceed $3.00 per patient day in fiscal year 1989-90 over and above the cost prior to 7/1/89. (HB 3600, 1989 laws, effective 6/89)

Pharmaceutical Providers/Methodology Study: Directs the SHHS Commission to conduct a study of reimbursement methodology for pharmacy providers who serve a disproportionate share of Medicaid recipients. Report must be submitted to the legislature by 1/90. (HB 3600, 1989 Laws, effective 8/89)

OTHER MEDICAID RELATED STRATEGIES

Medically Needy Program: Directs the SHHS Commission to implement a medically needy program by 3/1/90. (HB 3600, 1989 Laws, effective 6/89)

Nursing Homes: Calls for the authorization of 1500 new nursing home beds that will be Medicaid-certified, due to the long waiting list for such beds and limits on the home and community-based services waiver. (SB 573, 1989 Laws, effective 4/89)

INDIGENT CARE & UNINSURED PROGRAMS

Hospitals/Outpatient Services: Revises the South Carolina Medically Indigent Assistance Program requiring hospitals to provide up to $15 million of unreimbursed inpatient hospital care to eligible individuals. Eligibility will be established by the SHHS Commission based on family income and resources and determined on an episodic basis for a given spell of illness. (HB 3600, 1989 Laws, effective 4/89)

SOUTH CAROLINA CONTINUED

State Risk Pools: Creates the "South Carolina Health Insurance Pool," a risk pool for uninsurables. Establishes a commission to administer the program; eligibility criteria and coverage requirements; and a tax credit for participating insurers. The insurer will be selected through a competitive bidding process. Program excludes individuals covered under Medicaid, Medicare or other public programs, AIDS patients and those for whom the pool has paid out $250,000 in benefits. Pool will be financed by a tax on insurers. (HB 3216, 1989 Laws, effective 5/30/89)

SOUTH DAKOTA

BENEFITS & COVERAGE

No Changes

ELIGIBILITY

Spousal Impoverishment: Adopted rules for determining and treating exempt and non-exempt income and resources for spouses in long-term care. Set spousal share of resources at the greater of $20,000 or 1/2 the value of total aggregate nonexempt resource up to $60,000, or an amount determined by a circuit court. Law applies only to individuals institutionalized after 10/30/89. (HB 1075, Chapter 243, 1989 Laws, effective 7/1/89)

Transfer of Assets: In making the eligibility determination of applicants or recipients of long-term care, community-based services or home health services under Medicaid, this law allows the state to include as income all real or personal resources sold or given away at less than fair market value during the 30 month period preceding the application process. (HB 1041, Chapter 242, 1989 Laws, effective 1/26/89)

REIMBURSEMENT

No Changes

ADMINISTRATION & MANAGEMENT

No Changes

OTHER MEDICAID RELATED STRATEGIES

No Changes

INDIGENT CARE & UNINSURED PROGRAMS

Access Study Resolves that the executive board of the legislative research council undertake an interim study to develop an indigent care program. (HCR 1008, adopted 3/1/89)

TENNESSEE

BENEFITS & COVERAGE

MCH/Inpatient Hosoital Services: Provides unlimited inpatient hospital coverage for all infants under one year to the extent required by federal law or regulations. (SB 379, Chapter 296, 1989 Laws, effective 7/1/89)

ELIGIBILITY

No Changes

REIMBURSEMENT

No Changes

ADMINISTRATION &MANAGEMENT

Access/Cost-Containment Study: Establishes an 8-member Special Joint Committee to study the Medicaid program. Specifies legislative membership. Study will include an examination of the following: (1) proposed expenditures; (2) proposed new programs or expansion of existing programs; (3) any proposed changes in administrative or management; (4) policies established to comply with federal regulations; (5) facility planning for future needs and alternative uses of existing facilities or programs; and (6) alternative cost control programs and provision of services. Report is due to legislature by 1/10/91, at which time the committee will be terminated. (HJR 311, adopted 6/2/89)

Nursing Home Compliance/Sanctions: Changes state regulations to comply with the federal nursing home reforms on civil money penalties and other disciplinary actions. Authorizes the Commissioner of Health and Environment to impose civil money penalties on deficient nursing homes and to promulgate rules and regulations to do so. Authorizes the department to appoint temporary management, prior to the holding of a hearing, to oversee the operation of a deficient nursing home in the process of closing or making needed improvement. A person who notifies a nursing home of a pending inspection is subject to a $2000 fine. A person falsifying a resident assessment may be fined up to $1000 for each assessment and up to $5000 per assessment if the individual caused someone else to falsify the assessment. Penalties which are uncontested and paid according to law will be reduced by 10 percent. Persons have 30

days within notice of a penalty to make a written request for a hearing. (HB 646, Chapter 512, 1989 Laws)

OTHER MEDICAID RELATED STRATEGIES

Child Safety Fund: Establishes a "Child Safety Fund" within the General Fund to distribute funds to hospitals for the purchase child passenger safety systems. These will be given or loaned to parents of newborns. Reimbursement is based on percentage of Medicaid births up to a maximum of $30 per birth. Any excess funds will be distributed based on the fraction of additional funds that corresponds to the percentage of non-Medicaid births up to a maximum of $30. (SB 1110, Chapter 564, 1989 Laws, effective 7/1/89)

INDIGENT CARE & UNINSURED PROGRAMS

Access/Provider Participation Fund: Establishes "Health Access Incentive Account" to encourage providers to locate in designated underserved areas of the state. The Department of Health and Environment will assist in recruiting health professionals to provide services, including funding primary care residency rotations, reimbursing travel for potential practitioners, and developing a computerized tracking system to monitor and evaluate recruitment activities. Sets rules for funding; requires comments from cabinet council (established by Executive Order #1, l/20/,87). (HB 1170, Chapter 424, 1989 Laws, effective 7/1/89)

Local Health/Coordination of Services: Establishes "Community Health Agency Act of 1989". Authorizes Commissioner of Health and Environment to establish community health agencies to coordinate provision of health care services to indigent population. Targets four metropolitan areas and eight rural areas. Authorizes community agency to be political subdivision and establishes governing boards. Sets rules for membership and specifies duties and responsibilities of both Community Boards and Commissioner.

The Department of Health and Environment will designate rational service areas for obstetrical and primary care for each agency at least 180 days before the beginning of the fiscal year. Requires Boards to submit plan of operation 90 days before the beginning of the next fiscal year for review and approval of the Commissioner of Health and Environment, the Commissioner of Finance and Administration, and the Comptroller of the Treasury. The plan must include a budget for operating and capital expenditures, contracts for services, appropriate policies and procedures developed and adopted by the Board, and other items required by the department. For the first year, the plan may be submitted any time after 7/1/89. In subsequent years, each board must submit an annual report to the Governor. The Comptroller of the Treasury will conduct an annual audit. (SB 1296, Chapter 567, 1989 Laws, effective 6/8/89)

TEXAS

BENEFITS & COVERAGE

Elderly/CBS: Requires the state to inform individuals who are ineligible for a level of nursing home care that community services might be available under the Community Care for the Aged and Disabled program administered by the Department of Human Services (DHS). (SB 487, 1989 Laws, effective 10/89)

MCH/Case Management/Committee: Creates case management programs for high-risk pregnant women and infants under one year. Programs may be developed using contracts with public health entities, hospitals, community health clinics, physicians, or other appropriate providers. Case manager will assess the needs of the pregnant women and infants and serve as a broker for all necessary services including: (1) assuring that clients seek and obtain early and appropriate prenatal care; (2) assisting clients in gaining access to appropriate social, education, nutritional and other ancillary services in accordance with Medicaid law; and (3) assuring appropriate coordination within the medical community. Creates Maternal and Child Health Advisory Committee to advise the DHS on issues concerning pregnant women and children to maximize a coordinated system of services to this population throughout the state. Prescribes membership and duties of the committee. (SB 1678, 1989 Laws, effective 10/89)

Medically Needy Program: Reauthorizes medically needy program for pregnant women, children and caretakers with high medical expenses. (HB 1345, 1989 Laws, effective 9/1/89)

Rehabilitation/Respiratory Therapy: Establishes home respiratory therapy as an allowable service for ventilator-dependent persons. Also provides for physical therapy services. (SB 487, 1989 Laws, effective 10/89)

Respite Care: Authorizes hospitals to provide respite care. (HB 1345, 1989 Laws, effective 9/1/89)

ELIGIBILITY

MCH:

Income Standard: Extends income eligibility to pregnant women and infants with family incomes up to 130% of the federal poverty level and to children under 4 whose family incomes are below 100% of poverty. By 1991, Medicaid will cover children up

to age six whose family incomes are at or below 100% of the poverty level. (HB 1345, 1989 Laws, effective 9/1/89)

Presumptive Eligibility: Adds presumptive eligibility for pregnant women under Medicaid. (SB 1678, 1989 Laws, effective 9/89)

Nursing Homes/CBS: Raises the income limit to the federal maximum (300% of SSI) for nursing homes and 1115 (Demonstration) waiver programs. (HB 318, 1989 Laws, effective 9/1/89)

REIMBURSEMENT

Hospitals/Providers: Authorizes DHS to restore 3% of the 10% reduction in provider reimbursement in 1990 and add another 1.5% (for a total of 4.5%) in 1991. In its determination of prospective rates for inpatient hospital services, the department will assure that: (1) the rates are reasonable and adequate to meet the costs incurred by hospitals for services provided to Medicaid clients; (2) the payment methodology for hospital services sets the hospital specific standardized amount at a minimum level of $1,600; and (3) the adjustment in payment rates for disproportionate share hospitals takes into account the essential role of rural hospitals in providing access to hospital services to medically indigent individuals in rural areas. (HB 1345, 1989 Laws, effective 9/1/89)

ADMINISTRATION & MANAGEMENT

Case Management for Elderly: States that if the Department of Human Services, Department of Mental Health and Mental Retardation, Commission for the Deaf, Department of Aging or another agency receives funds to provide case management services to the elderly or disabled, the agency which receives the funds will provide information to their staff concerning the services other agencies provide to this population. (SB 487, 1989 Laws, effective 10/89)

Disproportionate Share Hospitals:

DHS Fund: Creates a special fund of not less than $5 million annually in state funds in excess of the 1990-91 appropriations bill to reimburse DSHs. (HB 1345, 1989 Laws, effective 9/1/89)

Hospital District Transfers: Specifies the amount that different hospital districts will transfer to the disproportionate share fund. (HB 123-X, 1989 Law, effective 9/89)

Hospital District Tax: Requires each hospital district with a licensed bed capacity at or above the 84th percentile of all hospitals participating in the medicaid program to transfer to the Medicaid disproportionate share fund 1% of the district's total ad

valorem appropriation taxes for the hospital's most recent audited fiscal year. Districts may subtract any collection expenses and uncollectibles directly related to the ad valorem tax collection. Specifies teaching hospitals and the amount they need to transfer to the fund. Transfers are due on July 15 of each year. Requires hospital districts and teaching hospitals to submit an audited financial statement to the department and the Comptroller of Public Accounts. Funds may not be used for department administrative costs, and the state may not reduce general revenue funding for the Medicaid program as a result of the new tax. (HB 123-X, 1989 Law, effective 9/89)

Notices for State Plan Amendments, Waivers, Pilots: Clarifies that DHS must publish the following: (1) any attempt to obtain a federal waiver in the Medicaid program; (2) any attempt to obtain funding for a pilot program in Medicaid; and (3) any amendment to the state Medicaid plan. The department is required to review the feasibility of requesting a home and community-based service waiver for the elderly in each biennial period in which nursing home rates increase. (SB 487, 1989 Laws, effective 10/89)

Nursing Homes:

Complaints: Directs the Department of Health to increase efforts to respond to complaints against nursing homes and have same-day or next day investigations when a problem is reported. (HR 791, 1989 Laws, effective 8/89)

Compliance/Patient Rights (OBRA '87): Directs state nursing home requirements to be amended to conform with federal changes. Includes changes in monitoring facilities, surveying facilities, enforcement, and patients' rights. (SB 487, 1989 Laws, effective 10/89)

Employees: Requires nursing homes to check prospective employees for criminal records. (HB 1466, 1989 Laws, effective 9/89)

Nurse Aide Training: Requires that when a nurse aide registry program is implemented, the department of health draft the rules needed to require all nursing homes and training entities pertaining to OBRA-87 requirements to use the registry program. All applicants will be subject to a criminal conviction check and that record will be included in the nurse aide registry as part of the person's record. (SB 332, 1989 Laws)

Reimbursement Methodology: Directs the DHS to make public the process used to determine payment rates for medical assistance. (SB 487, 1989 Laws, effective 10/89)

TEXAS CONTINUED

OTHER MEDICAID RELATED STRATEGIES

Hospitals/Nursing Homes: Directs the Department of Health to collect and analyze data on the cost of providing care to the elderly including inpatient hospital, outpatient hospital and nursing home costs. (SCR 117, 1989 Laws, effective 6/89)

LTC: Requires the DHS to develop programs to inform the public about the cost of long-term care, the limits of Medicaid and Medicare, and alternatives for financing long-term care. (SB 487, 1989 Laws, effective 10/89)

INDIGENT CARE & UNINSURED PROGRAMS

Hospitals/Counties: Specifies under the Indigent Health Care and Treatment Act that when a county sells a county hospital to a non-government entity, that hospital ceases to be a public hospital and the county assumes responsibility for providing health care services to county residents. If the county has contracted with the hospitals to provide health services to county residents, however, that care provided will count towards the counties' obligation under the act. (HB 630, 1989 Laws, effective 4/89)

County Health: Directs the Primary Health Care Services Program to target funds to counties whose hospitals have closed, are at risk of closing, or-are without a hospital. (SCR 54, 1989 Laws, effective 8/89)

Providers:

Dentists/Podiatrists: Adds dentists and podiatrists to list of providers that can participate in the Indigent Health Care Program (HB 1243 & 1211, 1989 Laws, effective 4/89 and 9/89 respectively)

Malpractice Liability: Directs the state to assume liability for medical malpractice claims against health care professionals who provide at least 10% charity care during the insurance policy year. Charity care is defined to include the state indigent care program, Medicaid, the Maternal and Child Health program, chronically ill children, the primary health care and migrant health programs. Such providers must still maintain malpractice insurance, but eligible providers qualify for a premium discount. (HB 18, 1989 Laws, effective 10/89)

State Risk Pool: Creates "Texas Health Insurance Risk Pool" to provide health coverage for individuals who cannot obtain insurance through other sources. Establishes a governing board, specifies membership, and designates rules and procedures for operation. Requires that the pool may not sets rates below 150% or above 200% of rates applicable to individual standard risks. Specifies eligibility and coverage requirements. Pool will be financed through state appropriations; if insufficient funds are available to support the pool, the insurance board may levy a tax on insurers operating in the state. (SB 832, 1989 Laws, effective 9/1/89)

UTAH

BENEFITS & COVERAGE

No Changes

ELIGIBILITY

No Changes

REIMBURSEMENT

Nursing Homes:

Cost-Containment: Supports a Medicaid moratorium that limits reimbursement to only those nursing home facilities certified as of 1/13/89. Any new facilities opened after that date are excluded form Medicaid participation. (SJR 8, adopted 2/20/89.)

Mental Health: Appropriates $2,375,000 for services to mentally ill and mentally retarded people residing in nursing facilities who are impacted by provisions of the OBRA of 1987. Under Utah law, the Department of Social Services (DSS) is the agency responsible for services to the mentally ill and mentally retarded while the Division of Health Care Financing (DHCF) is responsible fore Medicaid. Consequently, when any mentally ill or mentally retarded individual is transferred from an ICF or SNF to a community-based living arrangement, DHCF will contract with the DSS the amount equal to the General Fund which would have supported long-term care for these individuals. (HB 386, Appropriations, 1989 Laws, effective 7/1/89) Federal matching funds will continue for MR patients under a community waiver program.

ADMINISTRATION & MANAGEMENT

Providers/Fraud: Requires Department of Medical Assistance to establish rules, measures and sanctions for Medicaid providers who fail to comply with rules and procedures of the program. Funds collected as a result of sanctions shall be deposited in the General Fund as nonlapsing dedicated credits for the department to use in accordance with requirements. (SB 79, Chapter 165, 1989 Laws, effective 4/24/89.)

UTAH CONTINUED

Recovery/TPL: Allows the state department to recover costs of medical assistance from third party if state has provided assistance under Titles XVIII or XIX to individuals for which a third party is responsible. Department may place a lien on proceeds payable to that third party. Expands definition of "third party" to include trusts, estates, PPOs, CHAMPUS, workers' compensation, and a spouse or parent who has been appointed by the court to maintain health, dental or disability insurance of a recipient. Sets criteria for enforcing the lien. (SB 72, Chapter 163, 1989 Laws, effective 4/24/89)

OTHER MEDICAID RELATED STRATEGIES

Mental Health Services Waiver: Provides authority for the Department of Health Care Financing to continue to secure a HCFA waiver and to issues an RFP for the provision of mental health services to Medicaid clients under a capitated funding plan. The contractors would be free to provide necessary mental health and psychiatric services to all enrollees. (HB 386, Appropriations, 1989 Laws, effective 7/1/89)

INDIGENT CARE & UNINSURED PROGRAMS

No Changes.

VIRGINIA

BENEFITS & COVERAGE

The following changes were made through regulation:

Dental Services: Includes full banded orthodontics, tooth guidance appliances and dentures as additional procedures available through an EPSDT screening.

Organ Transplants: The state only covers kidney and cornea1 transplants due to regulatory action taken by the Board of Medical Assistance Services.

Prescription Drugs: Discontinues coverage of transdermal drug delivery system. Institutes coverage of self-monitoring test strips for diabetic children under 21 years of age.

Prosthetics: Mandates coverage of limited prosthetics, including artificial arms' and legs and their necessary supportive devises.

ELIGIBILITY

MCH: The Department considers pregnant women as eligible for services regardless of changes in family income for the entire pregnancy and through the 60th day following the end of the pregnancy.

Methodolonies: Due to order of the 4th Circuit District Court, the Department has discontinued the use of its more restrictive income and resource methodologies used in determining eligibility.

Spousal Impoverishment: Allows dependent spouses of institutionalized recipients to retain an increased allowance for their support. (HB 605, 1989 Laws)

REIMBURSEMENT

Methodoloav:

Hospitals/Inflation Factor: Requires the Department to incorporate into its inpatient hospital and nursing home reimbursement methodologies a Virginia-specific DRI inflation factor rather than a more general national factor.

Nursing Homes:

1. Dodge/R.S. Means Construction Index: The Department modified its nursing home methodology to substitute for the Dodge Construction Index the R.S. Means standard. The publishing company discontinued its publication the previously used standard.

2. Intensity of Services: Requests the Department of Medical Assistance Services to develop a reimbursement methodology for licensed and certified nursing home beds based on the intensity of the required services. (HJR 428, adopted 2/89)

Prescription Drugs: Limited reimbursement to one professional dispensing fee per legend drug per month for prescriptions dispensed to non-institutionalized clients. Revised client co-payment to $1.00 for all qualifying prescriptions.

Providers: Establishes certain levels of service delivery by which to determine if providers would be required to become enrolled providers or could continue to qualify for reimbursement as non-enrolled providers.

ADMINISTRATION & MANAGEMENT

Appeals: Expands existing law to include Medicaid applicants or recipients to appeals process for denial of aid, except when the appeal concerns payment levels or standards for determining level of need. (SB 437, Chapter 734, 1989 Laws, effective 7/1/89)

Disclosure: Requires Board of Medical Assistance to develop regulations for safeguarding the use or disclosure of information about Medicaid applicants or recipients for purposes not directly related to Medicaid services. Requires that regulations be consistent with federal laws; makes penalty for noncompliance a misdemeanor. (HB 1504, Chapter 67, 1989 Laws, effective 7/1/89)

Hospitals:

Licensure/Patient Rights: Requires hospitals to establish protocols relating to the rights of patients as a condition of licensure. (HB 1599, Chapter 434, 1989 Laws, effective 7/1/89)

Utilization Review: Allows the Department to waive all or portions of its inpatient hospital utilization requirements for specific hospitals.

Nursing Homes:

Compliance/Sanctions: Strengthens enforcement procedure against nursing homes found out of compliance with federal and state requirements including expanded authority to fine facilities, place them in receivership. (SB 786, Chapter 618, 1989 Laws, effective 7/1/89)

Nurse Aide Training: Provides for certification of nurse aides (C.N.A.) by the state board of nursing. Defines nurse aide practice as the performance of services requiring the education, training and skills specified in this chapter and performed under the supervision of a designated licensed health professional. Authorizes the board to certify and maintain a registry of all certified nurse aides and to promulgate rules consistent with federal law and regulation. All applicants except those certified by endorsement must pass a clinical competency evaluation in written or oral form to include the following areas: basic nursing skills, personal care skills, recognition of mental health and social services needs, basic restorative services and resident or patient rights. Renewal is biennial. (HB 1507, Chapter 278, 1989 Laws)

Preadmission Screening: Added OBRA '87 requirement to screen individuals having diagnoses of mental illness/mental retardation or related conditions to its existing nursing home preadmission screening program.

Reporting Requirements:

1. Requires nursing homes to provide to the State Board of Health on a quarterly basis the number of patients admitted by source of payment and the number of certified beds for Medicaid patients. (HB 1527, Chapter 699, 1989 Laws, effective 7/1/89)

2. Requires nursing homes to report to the Department of Health on patient injuries on a semi-annual basis. (HB 1580, Chapter 433, 1989 Laws, effective 7/1/89)

Review/Licensure: Authorizes that the review of nursing homes be brought under the duties of the Virginia Health Services Cost Review Council. The Council is also directed to provide consumers with information on hospital and nursing home costs that can be used and serve to increase competition. Adds the Director of the Department of Medical Assistance to Council membership. (SB 761, Chapter 261, 1989 Laws, effective 7/1/89)

TPL: Prohibits nursing facilities participating in the Medicaid program from requiring a third party guarantee of payment as a condition of admission, expedited admission, or continued stay in the facility. (HB 333, Chapter 193, 1989 Laws, effective 7/1/89)

Providers/Malpractice Liability: Includes licensed nurse-midwives in definition of"practicing Physician" regarding malpractice compensation for birth-related neurological injuries under Medicaid. Also increases the number of citizen representatives on the Birth-Related Neurological Injury Compensation Program from 1 to 3. (HB 1217, Chapter 523, 1989 Laws, effective 7/1/89)

VIRGINIA CONTINUED

OTHER MEDICAID RELATED STRATEGIES

AIDS/Waivers: Requests the Department of Medical Assistance Services to seek federal waivers to assist in providing services to adults and children infected by HIV. (HJR 427, adopted 2/89)

MCH/Access: Requests the Virginia Health Planning Board to study the decreasing access to obstetrical care and submit its findings and results to the Governor and Legislature in 1990. (SJR 168, adopted 2/89)

Local Health: Establishes the State Local Hospitalization Program within the Department of Medical Assistance Services. The program, financed by state and local matching funds, shall pay for inpatient and outpatient services, and services provided by free standing ambulatory surgical centers and local public health clinics, for eligible individuals. Eligibility will be established by the Department, but will at least include all persons with income at or below 100% of the federal poverty level, and resources equal to the SSI resource test. (SB 759, Chapter 746, 1989 Laws, effective 7/1/89)

Prescription Drugs: Establishes a joint subcommittee to study pharmaceutical costs in the Virginia Medical Assistance Program, to submit its findings and recommendations to the Governor and Legislature in 1990. (HJR 403, adopted 2/89)

Substance Abuse: Directs the Department of Medical Assistance Services and the Department of Mental Health, Mental Retardation and Substance Abuse Services to study the provision of substance abuse treatment services to persons who are eligible for medical assistance, to be submitted to the Legislature 1 1/89. (SJR 196, adopted 2/89)

INDIGENT CARE & UNINSURED PROGRAMS

Access Study: Resolves to continue the Joint Subcommittee on Health Care for All Virginians, that has been deliberating on the questions related to persons without health insurance and is to submit a final report to the Governor and Legislature. (SJR 214, adopted 2/23/89)

Hospitals/Uncompensated Care: Establishes the Virginia Indigent Health Care Trust Fund, within the Department of Medical Assistance Services, that will pay for charity care provided by hospitals. Funding will come from state general revenues and contributions from hospitals. (HB 1859, Chapter 635, 1989 Laws, effective 7/1/89)

VERMONT

BENEFITS & COVERAGE

MCH: Expands coverage for pregnant women and infants by eliminating the resource test. Appropriates $1,402,339 (included both federal and state funds) for this expansion. (HB 378, Act 94, 1989 Laws, effective 7/1/89)

ELIGIBILITY

No Changes

REIMBURSEMENT

MCH:

Providers: Increases reimbursement for total obstetrical care from $500 to $850. (Appropriations, effective 5/1/89)

Well-Child Services: Increases payments by 20% for well-child services under Medicaid. (HB 378, Act 94, 1989 Laws, effective 7/1/89)

ADMINISTRATION & MANAGEMENT

Nursing Homes/Patient Rights: Brings Vermont statutes into compliance with nursing home reforms under OBRA '87: Nursing homes must inform residents of their rights, including: (1) which services and items are or are not covered by Medicaid; (2) resource limits and allowable use of resident's income for items and services not covered by Medicaid; (3) the right to retain their bed while absent from the facility in the event of hospitalization, as long as hospitalization does not exceed 10 successive days; (4) the right to choose their own physicians and request a second opinion from a physician of their choice; (5) the facility's restraint policies; (6) grievance and appeals procedures; and (7) the right to review current and past state and federal survey and inspection reports of the facility. In the event of a transfer or discharge, residents must be notified in writing 72 hours prior to the transfer and 30 days prior to discharge. (HB 396, Act 71, 1989 Laws, effective 7/1/89)

VERMONT CONTINUED

OTHER MEDICAID RELATED STRATEGIES

Health Policy Council: Establishes membership on the Health Policy Council--two senators will be appointed by the committee on committees of the senate and two representatives will be appointed by the speaker of the house of representatives. (SB 73, Act 40, 1989 Laws, effective 7/1/89)

PHARMACEUTICAL ASSISTANCE FOR ELDERLY & DISABLED: (HB 228, Chapter 48, 1989 Laws, effective 7/1/90)

Administration and Management: Establishes a pharmaceutical assistance program for elderly and disabled individuals under the DSW to provide access to necessary prescription drugs and promote efficiency and effectiveness through cost controls and utilization review. The DSW may contract out for claims processing and related administrative functions. The Office of Aging will conduct education and outreach assistance and make information about the program available. The Commissioner of Taxes is responsible for notifying citizens that they may be eligible for the program using the yearly income tax forms and will be responsible for verifying income for eligibility purposes. DSW will adopt rules and criteria for establishing coverage limits, exclusion of allowable drugs, allowable charges and maximum quantities of drugs to be dispensed. The state has appropriated $103,700 for FY 1990 for the program with the provision that expenditures will not exceed $1 million in any fiscal year (the provision expires on 6/30/92). The Secretary of Human Services must make a report to the general assembly no later than 1/15 of each year containing recommendations on whether or not to include drugs that are not covered.

Benefits & Coverage: Coverage will be set by Department of Social Welfare (DSW) rules (see below) and will require copayments, which will also be established by rule by the DSW prior to the beginning of each fiscal year. The percentage of the copayment adopted by the DSW must be reasonably calculated to ensure that the state's obligation does not exceed funds appropriated for the program.

Eligibility: Individuals who are at least 65 years of age or disabled and whose family incomes are less than 175% of the federal poverty level are eligible to participate in the program.

INDIGENT CARE & UNINSURED PROGRAMS

Emolover-Based Health Insurance:

Part-Time Employees: Adds a clause to Vermont statutes prohibiting insurers from excluding part-time employees from group health insurance plans. Requires insurers to offer the same group health benefits to part-time employees that it offers to employee groups that the part-timers would be part of if they were full-time workers. The premium will be paid in full by either the employer or the employee, or through

a prorated rate with cost sharing between the employer and the employee. "Part-time" is defined as any employee who works a minimum of 17 1/2 hours per week. Applies also to nonprofit hospital service corporations, nonprofit medical services corporations and health maintenance organizations. (HB 279, Act 37, 1989 Laws, effective 7/1/89)

Small **Businesses and Individual Insurance Products:** Directs the Vermont Health Insurance Plan Board to design a small business partnership program and an individual health insurance program building upon existing public and private health care services. The Board's plan must include an implementation schedule and contain sufficient information to permit evaluation by the general assembly. A report is due to the assembly by 1/15/90. The Board must also establish a technical assistance program in conjunction with the private and non-profit sectors to help employers locate, evaluate and administer health insurance benefits for their employees. Appropriates $150,000 to develop the insurance products and $75,000 for technical assistance. (HB 378, Act 94, 1989 Laws, effective 7/1/89)

MCH: Creates a new program under the DSW using state-only funds to extend prenatal care to pregnant women with incomes between 185% and 200% of the federal poverty level who do not have health insurance coverage for such care. Also extends medical benefits for children through age 6 whose family income is less than 225% of the federal poverty level and who do not have health insurance. A small copayment is charged for well-child visits. Appropriates $91,699 to DSW for implementation of these two programs. (HB 378, Act 94, 1989 Laws, effective 7/1/89)

WASHINGTON

BENEFITS & COVERAGE

LTC/Disabled: (HB 1968, Chapter 427, 1989 Laws, effective 5/14/89)

The purpose of this law is to establish a coordinated and balanced range of community-based health, social, and supportive long-term care services to all chronically, functionally disabled individuals. The law directs the state to ensure the following: (1) a uniform and comprehensive assessment system to determine a client's level of functional disability; (2) service alternatives that minimize institutionalization and allow clients to receive care in their homes or in community-based facilities; (3) a state-wide case management system to effectively coordinate a client's plan of care; and (4) the development of a coordinated system of long-term care education that reflects both in-home care and institutional care needs of this population. In addition, the state is directed to develop an expanded network of volunteer providers (specifically for chore services) and to coordinate services among participating agencies to administrative minimize costs, avoid duplication, and maximize financial resources. To achieve these goals, the state will expand community-based long-term care services, such as chore services, respite care, personal care and hospice, case management services and adult family homes, to take advantage of these optional service categories under federal Medicaid directives. Expansion of services will require amendments to the state's Medicaid plan.

Chore Services: For clients who are at risk of being placed in a residential care facility, over 60 and eligible for 5 hours of chores services/month or less, the state is directed to provide those services through volunteer chore services providers under the Washington Senior Services Act (Chapter 74.38) rather than through paid providers. Individuals who are eligible for adult protective services are also eligible to receive emergency chore services without regard to income for up to 90 days if the services are essential to the protective services plan. If the state needs to make reductions in the program, they may make cuts by classes of eligibles rather than by cutting services. Individuals previously receiving chore services (both household and attendant services) under the state-only program are grandfathered into this program.

Personal Care Services: Plans of care for personal care services must be approved by a physician and reviewed by a nurse every 90 days. SB 5352-X appropriates $2.1 million for expansion of personal care services.

Respite Care: Requests an amendment to the state Medicaid plan to include respite service under its waiver program. SB 5352-X appropriates $3.2 million for enhanced respite care services.

Managed Care for AFDC recipients: Extends requirement for the state to enter into agreements with managed health care systems (defined as plans providing care on a prepaid capitated case management basis) for AFDC Medicaid recipients from 7/1/89 to 7/1/91. The amended law makes Washington statute consistent with federal language requiring only one county to have mandatory enrollment (clients may be enrolled in a number of plans instead of only one plan in a county). Allows the state to develop a number of managed care programs as long as the total enrollment on a state-wide basis is at least 30,000. (SHB 1560, Chapter 260, 1989 laws, effective 7/23/89)

ELIGIBILITY

LTC/Chore Services: Chore services are available to individuals who are not categorically eligible for such services under Medicaid and whose income does not exceed 30% of the state median income. For individuals with income greater than that, the level of chore services provided by the department will be reduced based on the client's ability to purchase the services. Eligibility assessment will be conducted using an instrument designed by the state; criteria will now include the client's level of functional disability and risk of institutionalization.

MCH: Services under the "Maternity Care Access Act of 1989" will be available to all categorically needy pregnant women and children under 1 year whose household income does not exceed 185% of the federal poverty level, and to children born on or after October 1, 1983 whose family income does not exceed 100% of the poverty level. Appropriates $21,961,000 in state funds for categorically needy pregnant women and infants and $4,420,000 in state funds for children under age 8. (HB 2244, Chapter 10, 1989 Laws, effective 8/9/89)

Spousal Impoverishment/Transfer of Assets: Requires the Department of Social and Health Services (DSHS) to establish rules in conformance with federal law for the allocation of income and transfer of resources between an institutionalized spouse and the spouse who remains in the community when determining eligibility for assistance under Medicaid. Allows the state to set the community spouse resource limitation at the maximum levels permissible under federal law (effective 10/1/89). The Department may waive a period of ineligibility if it determines that denial would create an undue hardship on the recipient. Eliminates language in the statues so that state law complies with federal regulations regarding transfer of assets between institutionalized and community spouses. (SB 5011, Chapter 87, 1989 Laws, effective 7/1/89)

WASHINGTON CONTINUED

REIMBURSEMENT

DSH: Makes Washington statutes compatible with federal definition of "Disproportionate Share Hospital" as included in the OBRA 1987. Methodology for reimbursement for these hospitals will be specified by Department regulations. (HB 1560, Chapter 260, 1989 Laws, effective 7/23/89)

Disabled Children: Requires the DSHS to establish a process for school districts to obtain reimbursement for eligible services under Medicaid for handicapped children so that state dollars can be leveraged to increase overall resources available for the school districts' special education programs. The program will be implemented in selected regions of the state during the first half of the 1990-91 school year, and extended state-wide by the beginning of the 1991-92 school year. The DSHS will be reimbursed by the Office of the Superintendent of Public Instruction (SPI) for the state-funded portion of medical assistance payments made by DSHS. The SPI and the DSHS must submit a joint report on the development of the interagency billing system to House and Senate legislative committees before 1/15/90. (SHB 2014, Chapter 400, 1989 Laws, effective 7/23/89)

MCH Providers: Appropriates $6.6 million in state funds to increase reimbursement levels to health care providers for delivery of maternity services under the "Maternity Care Access Act of 1989". Also, the DSHS is authorized to establish a loan repayment program that will encourage maternity care providers to practice in medically underserved areas in exchange for repayment of part or all of their health education loans. (HB 2244, Chapter 10, 1989 Laws, effective 8/9/89)

Nursing Homes: Increases nursing home reimbursement rates by 4.7% on both 7/1/89 and 7/1/90 to adjust for inflation. (SB 5352-X, Chapter 19, 1989 Laws, effective 7/1/89)

NURSING HOME REFORM: (HB 1864, Chapter 372, 1989 Laws)

Mental Health Services: Brings statutes into compliance with regulations set by HCFA regarding reimbursement of mental health services to nursing home residents. DSHS is directed to use mental health funding to services persons in need of active treatment in institutions of mental disease. (effective 7/23/89)

Noncompliance: The DSHS may deny payment for services to all Medicaid-eligible individuals admitted after a nursing home has been cited for deficiencies and did not correct those deficiencies within three months, or if the home has been found to be in violation of standards of care on three consecutive certification surveys. (effective 7/23/89)

Unallowable costs: Two items have been added to list of unallowable costs for reimbursement under Medicaid: (1) postsurvey charges incurred by the facility as a result of subsequent inspections which occur during the certification survey calendar

year; and (2) costs and fees, otherwise allowable for accounting and bookkeeping services, in excess of the 85th percentile of such costs reported by all contractors for the most recent cost reporting period. This limit does not apply if a contractor has not exceed the 85th percentile in any of the preceding annual cost reporting periods. (effective 7/1/89)

Providers/ Vendor Payments: Authorizes an overall average rate of increase in vendor payments of not more than 3% for 1990, and authorizes increases of not more than 2% for 1991. In determining the rate of increase for each vendor group the department may consider the gap between the vendor group's costs or market rates and the department's rate and the extent to which a disproportionate share of the vendor group's revenue or activity is dependent on clients receiving public assistance. These increases do not apply to hospitals and nursing homes. (SB 5352-X, Chapter 19, 1989 Laws, effective 7/1/89)

ADMINISTRATION & MANAGEMENT

LTC: (HB 1968, Chapter 427, 1989 Laws, effective 5/14/89)

Commission: Creates a long-term care commission. The executive committee will consist of 4 legislators, who will then choose 6 committee members who are experts in various aspects of the financing and delivery of long-term care services, 3 members who will represent long-term care consumers; 2 members who will represent county government and 2 members to represent the governor. The DSHS will also select 1 member from DSHS to represent the agency. The commission will develop legislation and recommend administrative actions to develop the following: (1) a coordinated and comprehensive long-term care system that offers a consistent definition of roles and responsibilities for all levels of government and private organizations in the planning, administration, and financing of long-term care services; (2) technical assistance for local communities to better meet the needs of the functionally disabled population; (3) a coordinated case management system; (4) a sufficient supply of non-institutional residential alternatives to care; (5) an alternative funding sources; (6) a systematic and balanced payment and reimbursement system; and (7) an integrated database to track long-term care clients. A report is due to the legislature by 12/1/90.

Hospice **Services:** The DSHS must provide to the legislature by 12/20/89 a report on hospice services, including an assessment of cost savings which may result from providing hospice services to persons who would otherwise use hospitals, nursing homes, or more expensive care. The hospice benefit will be terminated on 4/1/90 unless it is extended by the legislature.

Personal Care Services: Requires amendments to the state Medicaid plan to expand optional long-term care services. Rules will include financial eligibility indexed to requirements for Medicaid eligibility provided under Title XIX. A. report on

utilization and associated costs of personal care option must be submitted to the legislature by 1/1/90 and thereafter on an annual basis.

Respite **Care:** Expands agencies with which the DSHS may contract with for services; adds section to evaluate the mental and physical ability of the caregiver to perform necessary caregiver functions.

Mental Health Regional Network Plans: Appropriates funds to approve regional network plans through contracts negotiated with the DSHS. Plans must contain a fiscal plan to ensure that the increased costs for maintaining 1991 programs in 1992 will not unduly exceed the rate of inflation. Contracts will be negotiated in at least two competitive rounds; the first will be effective no later than 1/1/90, and the last round of contracts will be effective no later than 3/1/90. Appropriates $500,000 for planning and technical assistance grants to counties or regions who wish to form networks. First priority for funding will go to nursing home residents who are transferred because of requirements contained in OBRA 87. (SB 5352-X (Appropriations), Chapter 19, 1989 Laws, effective 7/1/89)

NURSING HOME REFORM: (HB 1864, Chapter 372, 1989 Laws, effective 7/23/89)

Information & Referral: The department in cooperation with area agencies *on* aging will provide printed information on the availability of long-term care services throughout the state, including options for community-based and residential services.

Licensure: The DSHS is now required to conduct one annual licensing and certification survey per calendar year and one postsurvey visit. The nursing home facility will not be charged for these two surveys; however, any additional surveys that are required beyond the first postsurvey to assure compliance will be accompanied by an inspection fee of $12 per bed. The fee must be paid to the department within 30 days of completion of the post survey (see reimbursement).

Recovery: Any emergency or transitional expenditures made by the department on behalf of a non-Medicaid certified nursing home may be recovered from revenue generated by the facility that does not go for operations. The Department may take action to recover the money at the time the expenditure is made regardless of whether or not the facility is Medicaid certified.

Compliance/Sanctions: Law modifies current statutes to comply with federal regulations affecting sanctions, stop payments, license suspensions, revocations, and receiverships. The DSHS may: (1) deny a nursing home license to an applicant; (2) stop placement of residents if the facility is found to be out of compliance with standards of care; and (3) order immediate closure of the home and/or immediate transfer of residents. The Department may also appoint a temporary manager to oversee operations, ensure the health and safety of the residents, conduct orderly closures and correct the deficiencies found by the Department.

Spousal Impoverishment: (SB 5011, Chapter 87, 1989 Laws)

Due Process: Establishes procedures for a fair hearing process to comply with federal law for the valuation of resources, community spouse resource allowance, or the monthly maintenance needs allowance. (effective 7/1/89)

MNA: Sets monthly needs allowance for community spouse up to the maximum amount allowed by state appropriations or within available funds and permitted under federal regulations but the allowance may not exceed $1,500. The current MNA is set at $1,000. (effective 10/1/89)

OTHER MEDICAID RELATED STRATEGIES

AIDS Insurance: Allows the state to use Medicaid funds to pay for health insurance coverage for persons with Class IV HIV infection who meet Medicaid eligibility requirements and are eligible for either group health insurance or continuation coverage under COBRA 1985. Has sunset date of 6/30/91 for coverage not initiated prior to that date. (SHB 1560, Chapter 260, 1989 laws, effective 7/23/89)

LTC:

Adult Family Homes: Gives legislative authority to DSHS to regulate adult family home services provided by the state. Directs the DSHS to develop rules and regulations for licensing adult family homes providing long-term care services. The licensing fee will be $50 per year per home and a one-time $50 processing fee for the initial application. Sets standards for licensing and grievance procedures, minimum requirements for home operators, standards for the homes and sanctions for non-compliance. (HB 1968, Chapter 427, 1989 Laws, effective 5/14/89)

CBS, Respite Care for AIDS: Directs the DSHS to request a waiver under section 1915(c) to provide community-based long-term care services to individuals with AIDS or AIDS-related conditions who qualify for (a) Medicaid or (b) the limited casualty program for the medically needy. Respite care services will be included as a service available under the waiver. (HB 1968, Chapter 427, 1989 Laws, effective 5/14/89)

MCH: (HB 2244, Chapter 10, 1989 Laws, effective 8/9/89)

Access: Requires the state to have in place by 1/1/90 the following procedures to improve access to prenatal care: (1) a shortened and simplified application form; (2) outstationed eligibility workers; (3) eligibility determination within five working days; and (4) county or regional plans for improved access. Also requires state to study feasibility and desirability of implementing presumptive eligibility and implement a broad based public education program that stresses the importance of obtaining maternity care early during pregnancy. Appropriates $4,8 17,000 for

maternity support services and $879,000 for administration and claims processing for eligibility expansion and case management services.

Case Management Support Services: Establishes case management services targeted to certain high-risk low-income pregnant women, such as teens and chemically-dependent pregnant women, under the "Maternity Care Access Act of 1989". Maternity support services for low-income pregnant women will include (but are not limited to) transportation, child care, psycho-social counseling and education, nutritional counseling, preventive services provided in the home and post delivery services. Appropriates $4.1 million in state funds for case management services and $4817,000 in state funds for maternity support services.

Medically Franile Children: Requires DSHS to develop a plan for providing inpatient skilled nursing services to medically fragile children. The plan must include the following: (1) criteria and evaluation methods for identifying medically fragile children in need of placement; (2) identification of in-state facilities that could provide such care; (3) standards for facilities providing such care; (4) a plan for providing care to this population; (5) identification of federal funds that could be used to provide long-term care services to these children; (6) an implementation plan; and (7) recommendations on legislative action needed to implement the plan. Requires the DSHS to submit a report to the Senate Health Care and Corrections Committee and the House Health Care Committee by 12/1/89. (SB 5903, Chapter 183, 1989 Laws, effective 7/23/89)

INDIGENT CARE & UNINSURED PROGRAMS

MCH: The "Maternity Care Access Act of 1989" is established to improve access to prenatal care services for low-income women and children in poverty (see Medicaid-Benefits and -Related Strategies) (HB 2244, Chapter 10, 1989 Laws, effective 8/9/89)

Standards & Recovery: Requires the administrator to prepare recommendations regarding standards for indigence to be applied uniformly among courts through the state. Directs the administrator of the courts in conjunction with the indigent defense task force to review the feasibility of implementing an indigent defense cost recovery program to recover state expenses for the indigent appeals program. A report is due to the House Appropriations and Senate Ways and Means committees by 12/1/89. (SB 5352-X, Chapter 19, 1989 Laws, effective 7/1/89)

Technical Corrections to the "Health Insurance Access Act of 1987": Allows the board of directors of the insurance pool to order an "accounting year" other than 12 months from time to time as may be required for orderly management of the accounting pool. Increases membership of the insurance pool board to eleven when self-insured organizations become eligible for participation in the pool. Allows the board to select an administrator from the pool membership regardless of whether the applicant resides in or out of state. (SHB 1067, Chapter 121, 1989 Laws, effective 7/23/89)

WISCONSIN

BENEFITS & COVERAGE

No Changes

ELIGIBILITY

MCH: Expands Medicaid eligibility to pregnant women and infants to 135% of the federal poverty level as of 7/90. The state implemented Medicaid expansions for this population with incomes below 130% of poverty using state general purpose revenue only on 8/14/89. (SB 31, Act 31, 1989 Laws, effective 7/90).

Spousal Impoverishment: Revises upward the income and asset requirements for an individual in the community whose spouse is in a nursing home seeking Medicaid eligibility as required by the Medicare Catastrophic Coverage Act of 1988. Adopts federal standards; implemented 9/30/89. (SB 31, Act 31, 1989 Laws, effective 9/89)

Subsequent to implementation, the 1989 Wisconsin Act 81 provided authority to further increase the asset limit to the federal ceiling of $60,000, effective 1/1/90. Thus, the asset limit is $15,000 for the period between 9/30/89 and 12/31/89. Projected fiscal impact of this changes is approximately $4 million (all funds) and $8.5 million (all funds) for FYs '90 and '91 respectively. (1989 WI Act 81, 1989 Laws, effective 1/1/90)

Transfer of Assets: Conforms state law with new federal requirement that prohibit the transfer of resources at less than fair market value for a period of 30 months, prior to applying for Medicaid eligibility for nursing home services. Implemented 8/9/89 (SB 31, Act 31, 1989 Laws, effective 9/89)

REIMBURSEMENT

Medicare Buv-In: Directs the state to pay the cost sharing requirements for Medicare eligibles with incomes at or below 100% of the federal poverty level. Implemented 8/14/89. (SB 31, Act 31, 1989 Laws, effective 4/90)

WISCONSIN CONTINUED

ADMINISTRATION & MANAGEMENT

Hospice Care Study: Requests a report from the Department of Health and Social Services (DHSS) on the cost-effectiveness of providing coverage of hospice care under the Medicaid program, to be submitted to the legislature by 10/90. (SB 31, Act 31, 1989 Laws, effective 8/89)

Nursing Homes/Patient Rights, Staffing: Revises nursing home requirements as outlined in OBRA '87, including services provided, resident's rights, and staffing levels and competency, and enforcement. (SB 31, Act 31, 1989 Laws, effective 10/90)

OTHER MEDICAID RELATED STRATEGIES

AIDS/Prescription Drugs: Establishes a program for individuals in need of AZT, who are (1) infected with HIV; (2) have less than $40,000 per year in income; and (3) are not eligible for Medicaid. (SB 31, Act 31, 1989 Laws, effective 1/90)

Health Financing Committee: Creates the "Special Committee on Health Care Financing" to function until May 17, 1990, the date established by the Assembly as the conclusion of floorperiod VII. Neither membership nor duties are prescribed in the law. (AR 15, adopted 4/27/89)

INDIGENT CARE & UNINSURED PROGRAMS

No Changes

WEST VIRGINIA

BENEFITS & COVERAGE

No Changes

ELIGIBILITY

No Changes

REIMBURSEMENT

Health Care Facilities/Capital Costs: Directs the state to reimburse health care facilities participating in the Medicaid program for their actual annual capital costs, if built after 4/81, for the period from April 1988 to March 1989. (HB 2598, 1989 Laws, effective 4/89)

ADMINISTRATION & MANAGEMENT

Aaencv Jurisdiction: Calls on all agencies involved in health care to cooperate, but clearly says no state entity may interfere with the discretion and judgement given the Medicaid agency (SB 576, 1989 Laws, effective 4/89).

MCH Providers/Liability Insurance: Requires the state to provide liability insurance for all medical practitioners who provide obstetrical services under the Medicaid plan. (SB 576, 1989 Laws, effective 4/89)

Nursing Homes:

Licensure/Compliance: Revises the enforcement procedure related to compliance with federal and state licensure and certification of nursing homes, in accordance with OBRA '87. (HB 2760, 1989 Laws, effective 4/89)

Preadmission Screening: Directs the state to screen residents in nursing homes for mental illness and mental retardation as required by OBRA '87. (SB 367, 1989 Laws, effective 4/89)

Protocols: Establishes appropriate protocol for making health care decisions for a nursing home resident who is physically or mentally incapable of doing so for themselves. (HB 2129, 1989 Laws, effective 6/89)

WEST VIRGINIA CONTINUED

Providers: Requires health care providers delivering services to the state, including the public employees insurance agency, to participate in the Medicaid program. Providers must maintain a Medicaid patient load of at least 15% of their total patient load. (SB 576, 1989 Laws, effective 4/89)

OTHER MEDICAID RELATED STRATEGIES

Uncompensated Care Study: Directs the Joint Committee on Government and Finance to study, or cause a study to be made, regarding the problem of uncompensated care and related cost shifting, to report back on the first legislative day in 1990. (HCR 49, 1989 Laws, adopted 4/89)

INDIGENT CARE & UNINSURED PROGRAMS

State Health Insurance/Demonstration Project: Establishes the "West Virginia Health Care Insurance Fund" for individuals without insurance, to be implemented by the public employees insurance agency. This will be accomplished by pooling in a group small businesses who do not offer insurance as well as individuals who are unable to obtain insurance. This new program is to cooperate with the state Medicaid agency to avoid an overlap in eligible persons, and also to use alternative coverage models used under Medicaid (i.e., work transition) in the new plan. The plan will begin as a three-year pilot with at least 2,000 enrollees, with reports due to the legislature in 1990, 1991 and 1992. (HB 2636, 1989 Laws, effective 7/89)

WYOMING

BENEFITS & COVERAGE

Home Health: Expands coverage to include chronic conditions. Eliminates requirements for home boundness hospital admission prior to receiving service. (effective 7/1/89)

ELIGIBILITY

No Changes

REIMBURSEMENT

Home Health/EMS Transportation: Converts home health and emergency medical transportation reimbursement from cost-based to fee schedule (effective 7/31/89)

Medicare Buy-in: Expands Medicaid services to cover premium, deductibles and coinsurance costs of Medicare hospital insurance under Part A and Medicare supplemental insurance under Part B for poor elderly, (HB 363A, Chapter 162, 1989 Laws, effective 3/3/89)

Nursing Homes: Revises nursing home reimbursement to specifically define allowable costs, limit maximum allowable operating costs and eliminate efficiency incentives to marginally efficient facilities. Changes inflation factor to an eight-quarter rolling average of GNP implicit price deflator. Payment for health care costs remained unchanged. (effective 7/1/89)

Providers: Establishes Medicaid-specific fee schedules for all professional services. (effective 7/1/89)

ADMINISTRATION & MANAGEMENT

LTC Pilot Project: Implements pilot project for on-site level of care determination for long-term care admissions by public health nurses in five counties to determine statewide applicability. (To become effective statewide in 1990)

MMIS: Implements Medicaid Management Information System. (effective 7/31/89)

WYOMING CONTINUED

OTHER MEDICAID RELATED STRATEGIES

Nursing Homes/Licensure: Enacted legislation not allowing licensure of new nursing facility beds including hospital swing beds for construction areas in which annual occupancy exceeds 92% of capacity, A construction area is defined as an area within 30 miles of the center of the closest community in Wyoming to a nursing facility using map mileage. New nursing facility beds are limited to 50% of the capacity in the construction area, except capacity may be increased by 10% or not more than 10 beds in any 2-year period. (HB 97, Chapter 35, 1989 Laws, effective 1/1/90)

INDIGENT CARE & UNINSURED PROGRAMS

State Institutionalized Patients: Requires the State Board of Charities and Reform to promulgate on or before October 1 of each year a schedule of actual costs for services and treatment provided to institutionalized patients for each state institution. The Board must keep a monthly account of actual costs and establish a charge for each resident. The charge schedule will include a sliding scale based on the resident's ability to pay. The Board may subtract capital outlays, real property repair, and maintenance to determine the benefit to the resident. The liability of a parent or spouse for a resident shall not exceed two years for cumulative care at the state institution; however, this does not limit the obligation of any third party payers for the resident. Indigent patients are the responsibility of the state. Admission to the pioneer home and the Wyoming retirement center shall be voluntary and only upon prior approval by the Board. (HB 249, Chapter 11, 1989 Laws, effective 6/8/89)

APPENDICES

APPENDIX 1

1989 FEDERAL LAWS AFFECTING MEDICAID AND INDIGENT CARE PROGRAMS

INTRODUCTION

Two federal laws relevant to Medicaid or indigent care programs were enacted during 1989. As in previous years, major policy changes affecting Medicaid were made as part of the budget law, the Omnibus Budget Reconciliation Act of 1989 (OBRA-89, P.L. 101-239) signed into law on December 19, 1989. The second major law related to Medicaid was the repeal of most provisions of the Medicare Catastrophic Coverage Act (MCCA) of 1988 (Medicare Catastrophic Coverage Repeal Act of 1989, P.L. 101-234), signed into law on December 13, 1989. This legislation did not eliminate the four Medicaid provisions which affect the following program areas: (1) coverage of pregnant women and children, (2) Medicaid "Buy-in" of premiums and cost-sharing for poor elderly, (3) spousal impoverishment and (4) transfer of assets. These provisions were outlined in the appendix of last year's edition of Major Changes; however, because there was substantial legislative and regulatory activity in the states around these issues, the provisions are again included in this appendix.

The major provisions of the two laws are summarized below to provide a brief overview of new requirements that all state Medicaid agencies or participating providers must abide by. Note that most of the technical amendments are not included in this summary. In order to be consistent with the format of this report, Medicaid provisions under OBRA-89 are listed according to the Medicaid category they affect (e.g. Benefits and Coverage, Eligibility, Reimbursement, Administration and Management, Medicaid Related Strategies and Indigent Care and Uninsured Programs). In addition, the section numbers of the laws are listed should readers need to find the complete text.

I. OMNIBUS BUDGET RECONCILIATION ACT OF 1989 (P.L. 101-239)

Although the annual budget bill is geared toward achieving a deficit reduction, all of the changes in the law affecting Medicaid will increase spending by both the federal government and the states. Continuing the trend of the last several years, most of the provisions expand coverage for maternal and child health care services and promote increased provider participation in the Medicaid program. All provisions are effective July 1, 1990 unless otherwise noted.

A. Benefits and Coverage

EPSDT: (Section 6403) Establishes a statutory definition of the current EPSDT benefit for children. Requires that states provide coverage for treatment to correct physical or mental problems identified during EPSDT screenings, even if the necessary follow-up services are not covered under the state's Medicaid plan. Directs the Secretary to establish annual goals for each state with respect to participation by eligible children in EPSDT. Effective April 1, 1990.

Nurse Practitioners: (Section 6405) Requires states to cover services of certified pediatric or family nurse practitioners practicing within the scope of state law, regardless of whether they are under the supervision of, or associated with, a physician.

B. Eligibility

MCH: (Section 6401) Requires states to extend Medicaid coverage to all pregnant women and children up to age 6 with family incomes up to 133 percent of the federal poverty level ($13,380 for a family of 3). Effective April 1, 1990.

QMBs: (Section 6411) States that determine Medicaid eligibility according to standards more restrictive than the standards for SSI (the "209(b)" states) must, like other states, pay Medicare cost sharing charges for Qualified Medicare Beneficiaries (QMBs), aged or disabled individuals with (a) income at or below 100 percent of the federal poverty level and (b) resources not exceeding twice the SSI resource-eligibility level.

C. Reimbursement

Disproportionate Share Hospitals: (Section 6003) For discharges occurring after March 31, 1990, the increase in the disproportionate share adjustment for urban hospitals with more than 100 beds and a disproportionate patient percentage of over 20.2 percent will be set at 0.65 percentage points for each 1.0 percent by which the hospital's disproportionate patient percentage exceeds 20.2 percent. For rural hospitals with more than 100 beds and hospitals classified as sole community hospitals, the disproportionate patient percentage required to qualify for a payment adjustment will be reduced to 30 percent. For sole community hospitals, the payment adjustment is increased to 10 percent. The formula for rural referral centers will be (P-30) (.6) + 4.0, where "P" is the hospital's disproportionate patient percentage. Hospitals that are classified as both sole community and rural referral centers will receive the higher of the applicable adjustments.

Federally-Qualified Health Center Services: (Sections 6402 and 6404) Requires states to cover ambulatory services for Medicaid-eligible pregnant women (Section 6402, effective July 1, 1990) and for other eligible individuals (Section 6404, effective April 1, 1990) that are provided by federally-qualified health centers (FDHC). FDHCs are defined as community health centers, migrant health centers, or health care for homeless programs, as well as clinics that meet the standards of those programs but are not actually receiving grant funds. States are required to pay these centers reasonable costs for services to pregnant women and children and 100 percent of reasonable costs for services to other recipients.

MCH: (Section 6402) Codifies current regulatory requirement that payments must be sufficient to enlist enough providers so that covered services will be available to Medicaid beneficiaries at least to the extent they are available to the general population in a particular geographic area. Requires states to submit plan amendments on an annual basis specifying payment rates for non-institutional obstetrical and pediatric care.

D. Administration & Management

MCH:

Care Coordination: (Section 6406) Requires state Medicaid plans to provide for coordination between the Medicaid and WIC programs, including notification of pregnant women and children under the age 5 who are eligible for Medicaid of the availability of WIC benefits.

Infant Mortality: (Section 6507) Requires Secretary to develop a national data system for linking infant mortality data with Medicaid services data.

Nursing Home Reform: (Section 6901)

Nurse Aide Training: Delays from January 1 to October 1, 1990, the requirement that nurse aides be trained and competent. Directs the Secretary to issue proposed regulations within 90 days. Clarifies that training and competency evaluation programs must address care to cognitively impaired residents. Requires states to offer nurse aides alternatives to a written exam, and prohibits imposition of charges on nurse aides for course materials or testing. Allows states to waive the competency evaluation (but not the training) requirements in the case of nurse aides who, as of the enactment, had worked for 24 consecutive months in the state for the same employer. Clarifies that enhanced Federal matching rates for nurse aide training apply to training conducted by nursing facilities.

Preadmission Screening: Postpones until October 1, 1990, implementation of regulations promulgated by the Secretary an February 2, 1989 relating to requirements for nursing facilities participating in Medicaid or Medicare. Directs the Secretary to publish proposed regulations for PASAR (Preadmission Screening and Annual Resident Review) criteria.

E. Indigent Care & Uninsured Programs

Demonstration Projects:

MCH: (Section 6407) Requires the Secretary to conduct demonstration projects with several states to test alternate ways of providing health care coverage to pregnant women and children under 20 whose incomes are below 185 percent of the federal poverty level and who are otherwise ineligible for Medicaid. The alternative forms of coverage could include, but would not be limited to, private employer group insurance, state employee group coverage, HMO enrollment and state basic health plans for the uninsured. Federal financial participation is limited to $10 million in each of the fiscal years 1990, 1991, and 1992.

Uninsurable Children: (Section 6508) Establishes 3-year authority for Secretary to continue up to 4 demonstration projects to provide health insurance coverage to medically uninsurable children under the age 19.

SSI/Disabled Children: Establishes a permanent SSI outreach program for blind and disabled children. Extends eligibility for SSI benefits to disabled children who reside with a parent who is a member of the U.S. Armed Forces assigned to permanent duty ashore outside the U.S., and who during the month prior to the parent's assignment abroad was receiving SSI disability benefits. Waives the SSI income and resource rules in the case of severely disabled children who were eligible for SSI while in a medical institution and who qualify for Medicaid under a state home care plan.

II. MEDICARE CATASTROPHIC COVERAGE REPEAL ACT OF 1989 (P.L. 101-234)

This legislation repeals most of the Medicare Part A and Part B provisions of the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) and restores the pre-MCCA Part A coverage and cost-sharing rules, including the spell-of-illness provisions, the 3-day prior hospitalization requirement for skilled nursing facility care and the 210-day limit on hospice coverage. The Part A provisions of MCCA, which included the expanded hospital, nursing home, and hospice benefits, became effective on January 1, 1989 and remained in effect through December 31, 1989. Transition provisions to adjust for the addition of these benefits are included in the law. Part B provisions, which included changes in monthly premiums and program financing, limits on beneficiary liability for Part B services, mammogram screening, respite care and the prescription drug benefit, were not scheduled to go into effect until January 1, 1990. This law did not repeal the Medicaid provisions in the MCCA. Thus, the states' obligations to expand coverage for pregnant women and children, and to pay the Medicare premiums, deductibles, and coinsurance of program beneficiaries at or below the poverty level, as well as the rules pertaining to treatment of income and resources for Medicaid beneficiaries requiring nursing home services (spousal impoverishment and transfer-of-assets rules) remain in effect. These are discussed below.'

A. Medicaid Coverage for Pregnant Women and Infants Below Poverty (Title III, Section 302)

Under the 1987 Omnibus Budget Reconciliation Act (OBRA-87), states were given the option to extend medical assistance to pregnant women and infants under the age of 1 with incomes up to 185 percent of the federal poverty level ($10,060 for a family of 3). This section of the legislation reauired the states to cover pregnant women and infants on a phased-in schedule. As of July 1, 1989, states were required to cover this population whose family income did not exceed 75 percent of the federal poverty level, and in July of 1990, states well to increase this income eligibility threshold to 100 percent. The OBRA-89 requirement to increase coverage to 133 percent of poverty supercedes this requirement. States are further prohibited from reducing their AFDC payment and eligibility levels below those in effect on May 1, 1988.

'The following summary is revised from last year's discussion of the Medicaid Provisions under MCCA found in the Appendix of Maior Changes in State Medicaid and Indigent Care Programs. 1988, prepared by Debra J. Lipson.

This section also requires states that have fixed durational limits on the length of inpatient stays covered by Medicaid to permit exceptions to these limits for medically necessary hospitalizations of infants under one year of age, so long as they are cared for in a facility that qualifies as a disproportionate share hospital. States that pay hospitals on a prospective basis must amend their state plans to allow for an outlier adjustment for infants care involves exceptionally high costs or long lengths of stay. This provision applies to treatment provided to infants on or after July 1, 1989.

B. Medicaid "Buy-In" of Premiums and Cost Sharing for Poor Elderly (Title III, Section 301)

Prior to the passage of the Medicare Catastrophic Care Act (MCCA), states were allowed to cover the premiums, deductibles and coinsurance for Medicare beneficiaries whose incomes were no greater than 100 percent of the poverty level. This section of the MCCA now reauires states to cover these individuals, as long as their assets are not more than twice the standards set by the Supplemental Security Income (SSI) program, which was $5,700 for an individual in 1988. This will be accomplished on a phased-in basis. States were reauired to cover those with incomes up to 85 percent of poverty as of January 1989, and must increase coverage to 90 percent in 1990, 95 percent in 1991, and 100 percent in 1990. States whose SSI standards are more restrictive than the federal government's were given an extra year to complete the phase-in. States using income standards higher than the required amounts will continue to receive federal matching funds for their coverage. The requirement to pay drug-related premiums, deductibles and coinsurance for eligible beneficiaries was repealed.

C. Treatment of Income and Resources: Spousai Impoverishment (Title III, Section 303)

This section of the MCCA revises a set of rules governing the amount of a couple's income and resources that can be reserved for the community spouse of Medicaid recipient in a nursing home. Formerly, the amount of income and resources allowed for the community spouse fell below the federal poverty level, leading to the problem known as "spousal impoverishment". The MCCA established rules that supercede state laws relating to community property and the division of marital property. The income of the community spouse is considered unavailable to the institutionalized spouse during any month in which a spouse is institutionalized, After eligibility for Medicaid is established, income paid to both spouses is divided equally. Resources held by either or both spouses are also divided equally, except that the couple's house and personal goods are not considered countable resources.

As of September 1989, the community spouse was permitted to retain a minimum monthly maintenance allowance of $786 in income (representing 122 percent of poverty for a family of two) plus an "excess shelter allowance" which includes the community spouse's expenses for rent or mortgage and utilities. The maximum monthly maintenance allowance cannot exceed $1,500 per month, except where a higher level is established through a fair hearing process or by court order. The minimum monthly allowance will increase annually so that it will represent 133 percent of poverty in **July 1991 and 150** percent of poverty in 1992. The community spouse may also retain at least $12,000 in assets, regardless of whether the assets are

held in the name of the institutionalized a community spouse. States are allowed to raise the asset limit up to a maximum of $60,000. Resources in excess of either $12,000 or the resource limit chosen by the state (whichever is higher) are considered available for the support of the institutionalized spouse.

This section also reinstates a policy that the Health Care Financing Administration (HCFA) attempted to modify in 1988. Medicaid-eligible nursing home residents must be allowed to deduct costs of medical care that are not covered by Medicaid from their income before contributing any income toward the cost of nursing home care. States continue to have the authority to place "reasonable limits" on residents' expenditures for medical care, such as those prescribed by a physician.

D. Treatment of Income and Resources: Transfer of Assets (Title III, Section 303)

This section of the MCCA requires states to make institutionalized residents ineligible for Medicaid if they have disposed of their resources, within a period of 30 months prior to application for Medicaid, for less than the fair market value of the asset. Previously, the period of ineligibility was 24 months. This does not apply to a house transferred to a spouse, a child under 21 years of age, a disabled or blind adult child, an adult child living in the house for at least two years before the parent was admitted to the facility and who cared for the parent, or a sibling who has equity in the house and lived in the house for at least a year before the person was institutionalized.

If resources were transferred for less than fair market value, the institutionalized person will be considered ineligible for Medicaid for either (a) the full 30 months, or (b) a period equaling the total uncompensated valued divided by the average monthly cost of care in a nursing facility for a private paying patient (not to exceed 30 months). Exceptions to the transfer-of-assets rules apply when the person can prove that reasonable attempts were made to obtain fair market value or the assets were disposed of for other purposes than obtaining Medicaid. This provision applies to resources transferred on or after July 1, 1988, with applicable state laws governing resources transferred before that date.

APPENDIX 2

FEDERAL POVERTY INCOME GUIDELINES, 1989

ALL STATES (EXCEPT ALASKA AND HAWAII) AND THE DISTRICT OF COLUMBIA

SIZE OF FAMILY UNIT	POVERTY GUIDELINE
1	$5,980
2	8,020
3	10,060
4	12,100
5	14,140
6	16,180
7	18,220
8	20,260

For family units with more than 8 members, add $2,040 for each additional member.

ALASKA

SIZE OF FAMILY UNIT	POVERTY GUIDELINE
1	$7,480
2	10,030
3	12,580
4	15,130
5	17,680
6	20,230
7	22,780
8	25,330

For family units with more than 8 members, add $2,550 for each additional member.

HAWAII

SIZE OF FAMILY UNIT	POVERTY GUIDELINE
1	$6,870
2	9,220
3	11,570
4	13,920
5	16,270
6	18,620
7	20,970
8	23,320

For family units with more than 8 members, add $2,350 for each additional member.

Source: Federal Reaister, February 16, 1989

INDEX

INTRODUCTION

To make this edition of Major Changes more "user friendly", we have included an index that will make the information more accessible to readers. There are two indexes: the first is arranged by the six main categories -- Benefits & Coverage, Eligibility, Reimbursement, Administration & Management, Medicaid Related Strategies, and Indigent Care and Uninsured Programs. Under each category, specific topics -- such as nursing homes, disproportionate share hospitals, maternal and child health, etc -- are arranged alphabetically. Next to each entry is the name of the state where the information may be found. The state profiles are arranged alphabetically and so should be easy to locate. The second index is arranged by topic and is the reverse of the first. A reader wanting to know about a certain topic may look in the second index under the specific topic (also arranged alphabetically) and find. the category (e.g.: Eligibility) and the state under which the topic is described. Many of the entries in the state profiles pertain to more than one category and are consequently listed under several headings. For example, a law concerning community-based services for developmentally disabled children would be listed in the topic index under three topics -- "community-based services", "developmentally disabled" and "children". Because the index is a new addition to this publication, we would appreciate any comments concerning the index's usefulness, problems readers may have using it or suggestions for improvements. Please address all comments or questions to Michele Solloway, IHPP, 2011 I Street, N.W., Suite 200, Washington, D.C., 20006. (Readers may also call (202) 872-1445 or FAX (202) 785-0114.)

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[1] Includes Funds set up for designated purposes that may not technically be "trust" funds.